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C. S. BRIGGS, A.M., M.D.
EDITOR AND PROPRIETOR

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Original Communications

THE CAUSATION AND DIETETIC TREATMENT OF RHEUMATISM.*

BY J. W. BRANDAU, M. D., CLARKSVILLE, TENN.

It was my original intention to confine this brief paper to a consideration simply of the dietetic treatment of rheumatism, but as it seems to me an attempt should be made to give some degree of scientific reason for allowing certain articles of diet and prohibiting others, it will be necessary, therefore, as best we can in the light of our present knowledge, to study the cause of the pathologic conditions known as rheumatism. The name rheumatism was first applied to catarrhal inflammations of the mucous membranes. Later it was applied to the condition now known as rheumatism by Sydenham, who was the first to describe it as a disease distinct from gout, the two diseases having been up to his time confounded under the name of arthritis. Several theories as to the cause of rheumatism have been advanced by different authors.

The *uric acid theory* was for a long time pretty generally accepted as the probable cause of the disease. Prout first suggested that the materies morbi was lactic acid. Todd, Fuller and others in England, and many of the older authors of our own country held this view until recent years.

*Read before the Montgomery County Medical Society December, 1906.

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It is true that there is a large production of acid in rheumatism, but this is one of the phenomena of the disease, a result of, and not a cause. Sir Benjamin Ward Richardson believed that the direct irritating effect upon the free surfaces of the endocardium by the acid in the blood was the cause of the endocarditis, but this theory would not account for the joint inflammations nor the pericarditis, which is almost as frequent as endocarditis, the latter occurring in about thirty per cent of all cases of rheumatism. If this theory were correct we would expect endocardial inflammation as an invariable complication. Dr. Richardson based his opinion on the redness of the endocardium found after death in dogs upon which he experimented by injecting lactic acid into the veins.

Reyher has since demonstrated that this redness is the normal appearance of the endocardium after death in all dogs, no matter how killed.

The *nervous theory* of the causation of rheumatism was first suggested by Dr. J. K. Mitchell. As an irritation of the floor of the fourth ventricle sugar is caused to appear in the urine, and as elevation of the body temperature is produced by irritation of Setchenow's center, so it is believed by the advocates of this theory that irritation or changes from exposure to cold, of certain nerve centers produces inflammatory changes in the joints, or the primary nervous disturbance causes errors in metabolism and the accumulation of lactic acid in the system from tissue degeneration is thereby produced.

The latest and most plausible theory ascribes rheumatism to a *microbe* which, it is now believed, multiplies in the organism in a manner similar to that of the malarial plasmodium (accounting for the successive inflammations of the joints and other structures involved), and in other specific processes, such as as gonorrhœa, scarlet fever and septic conditions, in which we also have arthritic and endocardial complications, and in which the germ goes on multiplying until destroyed by the antitoxin developed naturally or introduced artificially into the system. A close analogy may be traced in the clinical histories of malarial fever and rheumatism: (1)[c] Malarial fever irregular in type

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and varies in its course, so is rheumatic fever. (2) Profuse perspirations characterize the course of malarial fevers, as they do that of rheumatic fever. (3) During the course of malarial fever the urine is loaded with urates, so it is in rheumatism. (4) One attack of malarial fever renders the system more liable to its recurrence, the same is true of rheumatic fever. (5) Unless arrested by treatment malarial fevers are apt to have a protracted and uncertain course, the same is true of rheumatism. (6) The course of malarial fever is speedily arrested by large doses of quinine, the course of rheumatism by large doses of salicyl compounds.

It is evident that the poison of rheumatism, both in its history and effects on the system, bear a closer analogy to the poison of malarial fevers than to any other morbific agency, and, though these poisons are distinct and separate agencies, the analogies noted are sufficiently close to indicate the probability of their being allied in nature and in mode of action.

Streptococci and staphylococci have been found in the joints and other inflamed structures in rheumatism, but it is believed their presence was due to a mixed infection.

Mantle and others have described micro-organisms found in the blood, but up to the present time no organism peculiar to rheumatism has been found.

It is quite probable that the *ptomains* produced by the specific micro-organism may be the active poison which gives rise to rheumatism. This is a conclusion derived from the fact that from twenty to twenty-two hours elapse from the time of the administration of a germ feeding nitrogenous food before the rheumatic symptoms are brought on or exaggerated. It is believed also that it may be the ptomains of other micro-organisms which produce the joint and other inflammations similar, if not identically the same pathologically to those of rheumatism. This theory, if true, would account for those complications occurring in the course of typhoid, scarlet fever, and the other infectious diseases known to be caused by a specific micro-organism.

Gould says that, while as a rule each distinctive ptomain is

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produced by a different germ, there are instances of several bacteria producing the same ptomain. He describes a ptomain as being any one of the active inanimate septic or toxic substances resulting from the decomposition and disintegration of albuminous materials.

It is a matter of observation that nitrogenous or albuminous foods—foods rich in proteids—feed the micro-organisms of miasmatic diseases. Hence the increase in temperature in those fevers after the administration of such foods or their products.

Granting, therefore, that the specific micro-organism of rheumatism is similar in nature to those of the miasmatic diseases, we have the explanation of the fact that the foods rich in proteids feed the germs of rheumatism, accelerate their growth and development, increase the ptomain poisoning, and thus intensify the disease, or originate it in susceptible persons, namely, individuals with an inherited or acquired tendency to rheumatism. These being facts beyond question, it is a matter of surprise that some if not all of our latest text-books on medicine allow or recommend meats and other albuminous foods in the dietary of rheumatism. The following table arranged by Sir W. Roberts, shows the average per cent of albuminoid substances contained in different articles of food:

Animal Food.

Butcher's meat	19 per cent.
Fowl	20 per cent.
Game	22 per cent.
Fish	17 per cent.
Eggs	13 perlcent.
Milk	4 per cent.
Cheese	30 per cent.

Vegetable Food.

Bread	8 per cent.
Oatmeal	12 per cent.
Rice, green peas	6 per cent.
Potatoes	2 per cent.

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Carrots, turnips.....1–2 per cent.
Green vegetables, salads.....1–2 per cent.
Fresh or green fruits.....½–1 per cent.

Navy beans are not included in the above table, but they contain a large per cent of proteids. Bananas also contain a much larger per cent of proteids than other fruits. Butter contains a large per cent of proteids. Caffeine, the active constituent of both tea and coffee, is a nitrogenous substance and should be prohibited. Coffee also contains forty per cent of uric acid, while tea contains twenty-seven per cent of this substance. Alcoholic liquors favor the occurrence of arthritic disorders, and, according to Maclogan, should be prohibited.

In the above table it will be seen that there is little difference in the per centum of proteids in the different meats. This corresponds with personal observation in the use of meats as a diet. A small quantity of meat or other nitrogenous food produces a large increase in the development of the germ which gives rise to the ptomain poisoning. Less than one ounce of any meat, egg or oysters, or one-half ounce of butter or cheese is invariably followed in from twenty to twenty-two hours by general malaise, mental depression, constipation, scanty and highly acid urine, pains in joints and headache. If this diet be repeated successively for three days, or a larger quantity be taken for two days, some swelling of joints, sometimes a knee, a wrist, or the finger joints would occur. These symptoms were always promptly relieved by the administration of salicylates and vegetable diet. If, then, we exclude all meats and other substances rich in albuminoids from the dietary of our rheumatic patients, what shall we allow them?

1. All cereals, except beans and oatmeal.

2. All fruits, except bananas and nuts.

3. All vegetables, except tomatoes, which are objectionable principally on account of the large amount of acid which they contain.

4. An abundance of pure water should be insisted upon, as it favors elimination.

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Gynecology.

BY E. S. MC KEE, M. D., CINCINNATI, OHIO.

Ambidexterity in Gynecological Diagnosis.—The editor of the *Annals of Gynecology and Pediatry* calls attention to this point. He thinks too much stress cannot be laid on the importance of examining the right side of the pelvis with the right hand and the left with the left hand. The ability to palpate the left side of the pelvis with the right hand is very limited, as it is essential to bring the palmar surfaces of the index and middle fingers in easy relation to the side of the pelvis to be examined, that is, the examination of the left side of the pelvis with the left hand brings the palmar surfaces of the examining fingers in easy relation to any structure that lies between the right above and the fingers in the vaginal canal. The arm is not strained and the examiner can palpate with the least possible exertion and least pressure on the soft parts of the woman. It is also true in examining the right side of the pelvis with the right hand. In interpreting the true value of conditions found this ambidexterity will be found most helpful. The writer of this review is glad to have learned this ambidexterity early in life and has found it of very great value to him in unthought of occasions.

The following items of a gynecological nature are from the valuable little book, Surgical Suggestions, a collection of wisdom from the *American Journal of Surgery.*

The presence of sciatica demands a careful exploration of the pelvis by rectal or vaginal examination. It should be remembered that Osler described sciatica as one of the early symptoms of cancer of the breast.

Lymph-edema of the lower extremity associated with a swelling in the groin (fluctuating or not) is significant of carcinoma of the inguinal glands. The primary lesion may be in the rectum, *e. g.*, and epithelioma of the anus that is giving no symptoms.

In pulling on the round ligaments in Alexander's operation use the fingers rather than instruments; a surer hold is given,

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one can gauge the proper force to employ more readily and there is less likelihood of the ligaments tearing.

Sudden collapse after curettage for abortion may mean the rupture of an unsuspected ectopic gestation sac.

As a final cleansing step after curettage of the uterus it is well to introduce, and at once withdraw, a packing of gauze. This brings out with it fragments of tissue not washed out by the irrigation.

When cleansing the vagina for an operation a soft cotton mop should be used for the vestibule, a stiff brush is liable to bruise and lacerate the vestibule and cause dysuria for several days.

Cancer Research—Resume of Recent.—Bainbridge (Annals of Gynecology) states that cancer occurs with the same essential characteristics throughout the vertebrate creation. There is a variety of conflicting evidence in reference to the influence of diet on the development of cancer. It is found comparatively rare in hot countries, especially those whose inhabitants subsist largely on vegetables. With certain exceptions it seems to be prevalent where animal diet is largely consumed. Black races are remarkably immune, yellow races are more prone, while white races are the most susceptible. It occurs when the tissues are undergoing retrograde metamorphosis. Cancer is undoubtedly on the increase, especially in the alimentary tract. There are certain districts called cancer belts. They are low lying and damp areas. Women are attacked with cancer far earlier and more often than men. Much recent experimental work points to the cell as the essential element in the development of cancer. The parasitic theory is discredited by the Harvard commission. The report of the Imperial Cancer Research Fund destroys all known theories of the origin of cancer but proposes no new theory. Surgical treatment has been established on a finer basis than ever before.

Diagnosis of Cancer of the Uterus.—Jessett (British Gynecological Journal) says that at the cancer hospital they rarely meet with a case in its earlier stages, and a small percentage of cases present themselves in which an operation of any kind would be justifiable. One would think that cancer of the uterus would

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be as readily diagnosed as that of any other part of the body, and no doubt but that it would if patients presented themselves for examination early enough and if the family attendant insisted on a vaginal examination when the patient complained of vaginal discharge or any irregularity of menstruation. Women, however, through delicacy rarely consult their family physicians until the discharge becomes offensive or blood stained, or they suffer pain; even then they are too often treated with an astringent vaginal douche. We must insist on a thorough vaginal examination of every case where the slightest suspicion exists. It should not be laid at the door of the medical profession that through supineness they have allowed their unfortunate patients to drift into that condition where surgical aid is of no avail and condemn them to that end from which there can be no recall. It is not at all uncommon to meet with women who have recently been confined or aborted who have complained of hemorrhage for weeks afterwards and who, on being examined, have shown the development of cancer. It develops, or at least progresses, markedly after labor. Kelley says that all women over forty with laceration should be examined yearly.

Cancer Affecting the Glands.—Schauta, Vienna (Monatshifte fur Geburtshuelfe u Gynekologie), records much laborious research in the condition of the glands in uterine cancer. These results would indicate that the complete radical removal of the carcinoma of the uterus, with all the carcinomatous glands in relation with it, is possible only in the most exceptional cases, in which the glands are not affected at all. Ooederlein removed enlarged glands from the pelvis in sixty-five instances, and these were cancerous in 22.8 per cent of the cases, but in only nine per cent of the cases of cancer of the corpus uteri, and in those the disease had broken through the uterine wall. Pankow reports that he removed the glands in forty per cent of all cases operated by him, and only fifty per cent of these proved to be cancerous. Mackenrodt, Berlin (Monatshefte f Geb. u Gyn.), finds that in ninety-five per cent of all cases in which the glands are affected only those of the first line are so. The rare affection of the

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glands of the second line are far less dangerous in regard to local recurrence than those of the first line close to the cicatrix. Kroemer, Giessen (Arch fuer Gyn.), from his observations thinks there can be no doubt but that while the lymphatics become somewhat early invaded when adeno-carcinoma exists in the cervix, extending into the parametria, yet in those cases when the disease is limited to the fundus the lymphatic system is rarely, or at any rate tardily affected. Jessett (British Gyn. Journal) says that his experience, based first on the examination of a large number of women in the post mortem room, led him to the conclusion that glandular infection did not occur nearly so frequently as was imagined; even in patients who had died of advanced cancer of the uterus he had found but little infection of the pelvic and iliac glands.

Gynecologic Souvenirs.—Reverdin, Paris (Revue de Gynecologie Paris), writes from his "Anecdotage" an interesting sketch of the rise and development of gynecology in France, and of various national and international gatherings of specialists. He particularly comments on the greater confidence and liability of better results when a surgeon is operating in his accustomed environment. An invitation to operate when visiting a clinic away from home should not induce a surgeon to perform an operation involving risk of life, merely because his vanity has been flattered by the invitation and the deference shown him. He advances this merely as his opinion, but confesses that it is based on several unfortunate personal occurrences. The great benefits of visiting others' clinics and operating rooms he amply extols, saying that this intercourse with other minds and techniques is one of the chief advantages of congresses, and that he does not agree with Mme. de Stael's dictum, "When men are congregated together their ears lengthen out."

Gonorrhœa and Diseases of the Female.—Noegerrath states that eighty per cent of men have had gonorrhœa, that ninety per cent of such are never thoroughly cured, and three out of every five married women have this disease.

Fitch says, and judging from observations he is justified in so stating, "that out of every one hundred women who marry men

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who have had gonorrhœa ninety are ailing from disease of the reproductive organs, and that the other ten have some gonorrhœal ailment."

Eighty-five per cent of disease of the female genitalia is caused by gonorrhœa, and forty to forty-five per cent of the operations on these organs are due to the same cause. One step further, thirty per cent of sterile marriages, and fifteen to twenty per cent of blindness have a cause in the same disease. Although the gonococci are the cause of practically every case of urethritis in man, they are not always the cause of the pelvic inflammatory action in the female. In other words, a man contracts gonorrhœa. In the course of time all discharge ceases, and with the exception of a small shred or two the urine may be perfectly clear. If we now massage the prostate gland and ampulla, in a goodly number of cases, pus appears at the meatus. By careful microscopical examination gonococci are occasionally found, but in the great majority only strepto and staphylococci can be demonstrated, with an occasional colon bacillus. Strepto-and staphylococci, although not always as virulent as the gonococci, are just as dangerous, for they persist long after the latter have disappeared.—*Medical Progress.*

The Prophylaxis and Treatment of Pyo-Salpinx.—West (Annals of Gynec. and Ped.) concludes: All cases of abortion should be operated upon. Gonorrheal invasions should be fought until all traces have disappeared. The greatest possible aseptic precautions should be used within the uterus. All cases of pyo-salpinx should be operated upon. Some cases may be relieved by proper drainage. Radical operations should not be the rule in every case. The vaginal route is unsuitable for radical work. In freshly inspected cases, West has had encouraging results by washing out the uterus through a cervical speculum with an alkaline solution, followed by 1-240 solution of silver nitrate. Pyo-salpinx, due to incomplete abortion, can be entirely prevented by operating upon every case of inevitable abortion under anesthesia. A large abscess lying in the cul-de-sac should be treated by a vaginal incision with drainage tube left in situ for five weeks.

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Value of Blood-Counts in Gynecological Diagnosis.—Newmann (Wiener klin. Wochenschrift), in a great number of gynecological cases examined the blood, and comes to the following conclusions: Purulent processes of the perimetrium and adnexa show, as a rule, a leucocytosis, which decreases as the condition becomes localized. The leucocytosis may be present in very acute pus formations; it is also absent in debilitated individuals. A leucocytosis of over 15,000 is a definite indication of pus formation. Benign tumors produce no leucocytosis, though a moderate rise is found in malignant growths. A failure to demonstrate leucocytosis does not exclude infection.

Paravaginal or Abdominal Operation in Carcinoma of the Uterus.—Gellhorn (St. Louis Medical Review) comes to the following conclusions:

1. The radical abdominal operation, as far as the routine ablation of the lymphatic organs of the pelvis is concerned, has thus far failed to yield the desired results.

2. On the other hand, the eradication of the parametria has been found to reduce greatly the percentage of cures.

3. Consequently, the simple abdominal and vaginal operations which do not include this procedure must be discarded.

4. For the extirpation of the parametria Wertheim's method is the best of the abdominal operations.

5. It has, however, certain advantages compared with the paravaginal method of Schuchardt.

6. Considering the encouraging results of igniextirpation, a combination of thermocautery with paravaginal extirpation gives promise of further improvement in operative results.

A Christmas Story.

BY E. S. M'KEE, CINCINNATI, OHIO.

About eighteen years ago I was called to see a patient, a recent arrival from Russia, whom we will call Mrs. Blankstein. She was very ill indeed, and I found it necessary to see her every day for a month, commencing December 15. She recovered and in due time I sent my bill. In somewhat overdue time her

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husband came to my office to pay it. The following was his plea: "Mr. Doktor, dat bill you zendt mein vife, he's all dright, but vone dem visits you makes mein vife you makes him ond a Ghristmas day, and I vandts you make me a bresent dat visit you makes mein vife ond a Ghristmas day." The request was so original, coming from the source it did, so different from the usual demand for a per cent off, that I threw off the visit, made him a "bresent" of it, instead of charging him double, as I felt like doing, for being taken away from my Christmas turkey.

I have had many times the worth of the presented visit telling it to my friends. Almost every Christmas since this occurred I have been called to some sufferer, poor in this world's goods, and before leaving I have told the story of the Christmas present of a visit and made the patient a present of the Christmas visit I was then making. The happy smile, the brightened eye of the pale patient has been my reward for working while the rest of Christianity was feasting.—*Journal American Medical Association*, Dec. 23, 1905.

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Selected Articles

The Opsonins.

A lecture to the Senior Medical Class of the College of Physicians and Surgeons of San Francisco.

By H. D'Arcy Power, L. R. C. P., L. S. A. London, Professor of Theory and Practice of Medicine.

Ladies and Gentlemen: For the past three months we have been engaged in the study of the physiology of morbid conditions in general and of the infectious diseases in particular—and these studies, together with your previous work in bacteriology, will enable you to easily comprehend the basis of the important subject I am to bring before you this morning.

Ever since it became evident that the infectious diseases were directly due to the growth of living organisms, a solution has been asked to the question why should they, having made good their entrance and occupied the field, pass away and leave their unwilling host free from their presence and morbid effects. If they could prevail against the body cells when they were few, why should they lose the battle when they are many? Why again are certain individuals immune? Why does infection with some species give future immunity, with others greater susceptibility? To these questions, as you know, partial answers have been given, but no single statement has commanded general acceptance.

We have the chemico-humeral theory whereby a solution is sought in the chemical interaction of microbic products and those of the body cells and blood; which, at least, has this element of certain truth that there are substances produced by the host capable of causing the death of the invading germ (Bactricides), and there are also substances capable of neutralizing chemically or physiologically the effects of stable bacterial toxins (anti-toxins). There is no need of going into this question any further. We also

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have the theory associated with the name of Metschnikoff that the lessening of a microbic disease is dependent upon the act of the leucocytes who devour and destroy the cause of the disease. I am about to devote myself to this phase of the subject this morning. If you go back to the basis of the cellular theory you will find it simple in its origin. Most uni-cellular organisms have the power of ingesting foreign material for food purposes. Take the many forms of protozoa, and we find them ingesting various substances, and by the process of digestion, liquefying the same, and utilizing these foreign materials for the growth of their own protoplasm. What is true of the uni-cellular organisms in nature is true of the homologous leucocytes in the body. Like to its free brother in the pond, it takes in foreign material and digests it, and incidentally in doing this it may destroy the germ of a disease. This is called phagocytosis. The uni-cellular organisms in nature show food preferences. The same is true of the leucocytes, and this food preference is called chemiotaxis. Now it is quite clear that the question of chemiotaxis is an all-important one. If the leucocytes in a given case of infection do not have this food preference, they will not ingest the germs and there will be no cure. It has been observed that this preference for microbes changes; the leucocyte does not maintain forever its preference or aversion for a certain germ, etc. The question arises, What is the reason for this change? Is it due to a change in the leucocytes? Does its relation to the food presented alter? Just as the tastes of higher animals alter in regard to foods, or is it due to a change in the food itself? The leucocytes either alter their relationship to the food or the food may undergo a change fitting it for digestion, which we are not able to recognize. I shall now give you some experimental facts. Take the growth of streptococci grown "in vitro" and mix them with a number of leucocytes that have been separated from the blood plasma and washed. I shall not go into the details of the process, but it can be done. These leucocytes are however still alive, showing amœboid movements, and if they are thus mixed with a streptococcic culture they will not ingest cocci. They *have not* acted as phagocytes. Now, if you throw the culture of streptococci into the blood, or if the strep-

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tococci get into the blood through an infection and we examine this blood, we find the streptococci within the leucocytes. In this case they *have* acted as phagocytes to the streptococci. We therefore have a change in the leucocytes which is not effected outside of the body. Now, take the streptococci grown in pure culture and mix with washed leucocytes, and then commence to add a small quantity of blood serum gradually, say at first 0.125 cc, and you will find that on the average every leucocyte will contain about two micrococci. Now increase this to 0.25 cc and let it stand for a quarter of an hour and each leucocyte will contain an average of 7 cocci; increase to 0.5 cc and get an average of 14 cocci; 1.0 cc and get 19 cocci; t.0 cc and we get an average of 23 cocci in each cell. So you see the ability of these leucocytes to ingest streptococci has arisen with the proportion of blood serum present in the mixture. However, this cannot go on indefinitely, as the capacity of the leucocytes has a limit, but we have an increased power of the leucocytes as the amount of serum is increased. Again, let us take some of the streptococci from the same growth and mix with serum and after an interval wash all the serum off and return them to the glass slide and mix them with washed leucocytes and we *now* find the leucocyte will ingest the streptococci. That which the leucocyte could not do at first it does now. We have then the demonstration of the fact that there is something in the serum of the blood that renders the cocci capable of ingestion by the leucocytes. What it is we do not know. This material is termed opsonin, and it is absolutely necessary to change the chemiotaxis of the leucocyte to the germ. The amount of opsonin in a given sample of blood can be estimated relatively by the number of micro-organisms that the leucocytes can take into themselves. Let us see how this is done. Take a culture of the given micro-organism which we wish to test and by a process of dilution reduce it down to a definite number of bacilli in a given amount of fluid, then mix a known quantity of this culture with a known quantity of blood and leave it in contact for fifteen minutes; by this time the leucocytes have ingested their limit of bacilli; then count a given number of leucocytes under the microscope and then count how many bacilli there are in

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each leucocyte, divide the number of bacilli by the number of leucocytes and we have the average number of bacilli to a leucocyte, which increases with the proportion of opsonin present in the blood. That the amount of opsonin in the blood is limited may be shown by digesting successive batches of bacilli with blood serum, when it will be found that the later digestions are no longer ingested by washed leucocytes in vitro. The relative amount of opsonin is spoken of as the "opsonic index" and, like in the case of haemoglobin determinations, is estimated by comparing the average number of a given bacillus ingested by one leucocyte of a normal healthy man, with the average number per leucocyte of the individual under observation. This opsonic index differs with different bacilli and with different strains of the same species, and fluctuates to some extent in the normal individual. It is well to note at this point that the opsonin does not in any way enhance the phagocytic power of the leucocytes by acting on them individually. Leucocytes bathed in serum, rich in opsonin, and then washed have no power to ingest bacilli grown in vitro, unless the bacilli be also bathed in the serum, therefore, drugs that merely increase the number of leucocytes can be of no value unless the opsonin is also increased. Leucocytosis does not necessarily mean an equivalent phagocytosis.

If the cure of an infection is dependent on an active phagocytosis and that is in turn dependent on the amount of opsonin present, the great therapeutic problem will be, How to increase the amount of opsonin in a given case?

As you know it is a physiological principle that supply grows with demand. Exercise a muscle and it hypertrophies; give a meat diet and pepsin and trypsin increase in their respective secretions. Increase beyond the normal the fats in a dietary and the steapsin follows suit, hence if we make a call on the body for opsonin by injecting therein the bacilli that absorb it, we stimulate its production and an increased supply follows. It is upon this principle that Sir A. E. Wright's remarkable successes with bacterial vaccines are founded. These vaccines are sterilized cultures of the bacillus whose presence in the body is the cause of the disease to be cured. They should be made from bacilli taken from

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the diseased area, for their opsonins vary not only with different bacilli, but with different strains of the same species. The culture having been made and sterilized, a definite quantity representing a given number of bacilli is injected into the patient; these bacilli use up a portion of the free opsonin and the index falls. This drop in the opsonic power of the blood is called by Wright the negative phase, then it increases to a point higher than that present before injection (the positive phase); still later it will again tend to fall. As soon as the second fall begins a fresh injection is given, and a new negative and positive phase results with the index carried higher than by the first injection. So the treatment is continued until no further increase of the opsonic index is obtained or the disease is cured. Now, as the rise in the opsonic index means enhanced phagocytic power, and removal of the offending bacilli, so does the negative phase mean a lessened check on the bacilli with increased virulence of the disease. It is therefore possible in the case of a severe infection that a large initial dose of the vaccine might produce a negative phase of such severity as to endanger the patient, hence the need of small initial doses. Again, when the vaccinations are repeated, it is essential that they be given at the first indication of a fall, or the second positive phase may give no more opsonin than the first. All this means that not only is it necessary to take the opsonic index before and after the injection, but repeatedly, preferably each day.

Next, let us consider the class of cases that are likely to be benefited by this treatment. First, it is to be remembered that all microbic diseases are not curable by phagocytosis, and for such an increase in the opsonin can be of no value.

Secondly, where there is a bacteriæmia and the blood is already full of bacilli, the addition thereto of more bacilli, though dead, can only make matters worse; but where the disease is localized, as it is in tuberculosis, most pus formation due to streptococci, staphylococci, pneumococci and gonococci, all these being subject to phagocytosis, we may expect good results by increasing the opsonin in the blood circulating through the part; and it is in this class of cases that Wright and his followers have had marked

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successes. Chronic staphylococcic infection of all kinds, old sinuses, boils, acne, streptococci lesions, infections with the B. Coli and the gonococcus, tubercular lesions of the skin, bones, peritoneum and lungs; all these singly and in multiple infections have been cured in both acute and chronic forms. You must bear in mind that opsonin is the name of a class and not of a definite substance, and different bacilli require different opsonins. Therefore, in a mixed infection the index must be taken for each of the invaders, and cultures and injections made accordingly. Only in this way can many cases be cured. I will read you the notes of one case of this kind reported by Drs. Turtin and Barkin.

"The ingrafting of other organisms on the tubercle bacillus is well illustrated by Case 9, in which after six weeks draining of the tuberculous kidney the patient was treated with tuberculin; six weeks later the staphylococcus albus having been found in the discharge and the sinuses not healing, the patient was treated with a vaccine from this organism which vaccine raised the staphylocci index from 1.15 to 1.5. After these injections combined with the tuberculin, healing became rapid and finally complete."

When we remember that cases of this type have always been the opprobrium of medical science, we shall have good reason for rejoicing. Consider the disfigurement of lupus, the annoyance of sycosis and acne, the hopelessness of a tuberculous kidney and you will see that the public have equal reason to hail a discovery that bids fair to equal in importance the greatest of those of the past.

Incidentally it explains some of the mysteries of empirical treatment. Thus local diseases are often benefited by various manipulations and some like tubercular peritonitis by simple incision. It may well be that in these procedures bacilli are forced from their nidus into the lymph and blood streams and then act as stimulants to the production of opsonin, just as does the injected vaccine. Again, certain infections are benefited by sera, such as the antistreptococcic. It has been experimentally shown that these sera act on bacilli in the same way as the blood serum, rendering cultures grown in vitro susceptible to phagocytosis by washed leu-

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cocytes. Their action is thus explained. Finally, we have learned that there are both endogenous and exogenous substances that inhibit opsonic action, among these notably lactic, and probably other organic acids. When we remember the excessive production of acids in rheumatism and diabetes we have a clue to the susceptibility the victim of these diseases show to purulent infection. These are some of the leading facts of the most promising discovery of recent times. Much is yet to be done and it is probable that the benefits already in operation will be extended to other fields. Thanks to the quicker appreciation of truth that characterizes the present day, an army of skilled observers in this country and Europe are already checking and elaborating the work of Sir Almroth Wright and the question whether a member of the British school of medicine shall have done for internal treatment what Lister did for surgery, is likely to have an early solution.—*Pacific Medical Journal.*

Mens Sana in Corpore Sano.

BY DAVID W. CHEEVER, M.D., LL.D., BOSTON.

The mind cannot exist in our present world without the body; and no healthy mind without a healthy body. This I consider an axiom.

The one exception is a bright intellect surviving in a sick body. This is a hectic fire, flaming uncertainly, and often consuming the crucible. But this is not a healthy mind, for the latter is even, tempered, uniform. The eccentricity of genius is like an electric light, brilliant, dazzling, but unnatural.

The healthy mind corresponds to its surroundings, burns evenly, repairs its waste, lasts as long as the healthy body.

One hardly needs to reflect to realize the constant influence of the organic functions of the body on the moods of the mind.

A sick man, a morbid mind: melancholy distils black bile.

As the old observers pointed out, all maladies situated below the diaphragm depress the spirits. The vagaries of dyspepsia influence the mind equally with the body. A good digestion means good nature, cheerfulness and calmness.

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The clogging of any excretion dulls the mind. Free excretion, whether of skin, kidneys or bowels, clarifies the mind; every thought and every emotion. Fasting, even, purifies and sharpens the mental action.

It is especially requisite that the physician should possess the healthy mind. If otherwise, he is no fit adviser for the sick. In all sickness the mind of the patient is shrunken and changed.

But he who tries to administer solace, relief, cure, must be healthy, or he fails lamentably. What more depressing than a half-sick doctor? Pessimism is his natural bent, but optimism is his one essential need to cheer the sick man. The physician must be hopeful, or the patient sinks under his load of fears and morbid imaginations.

If then the body rules the mind so largely, it is doubly important that the doctor consult and preserve his health. Does he?

It is a common observation that physicians share the habits of their fellow-beings.

The first great law of health is regularity, periodicity, in everything. The hours of meals, of rest, of work, if uniform, are the best of preservatives. But the doctor is sometimes unavoidably, and sometimes needlessly, more irregular than other men. He cannot avoid loss of sleep; he cannot always be punctual at his meals. This is true of all our hard-worked profession, in country or in town. Perhaps it is most especially true of the hospital doctor.

Health demands that the interval between meals should not exceed five hours. And that all meals be taken within twelve hours, leaving twelve hours for rest, and assimilation in sleep. For instance, a breakfast at eight o'clock means a luncheon at one and a dinner at six.

One hour of variation, on either side, may be safely allowed, but no more.

Every employe of a hospital is given a nooning and a lunch. The doctor, whether chief or house-officer, is not. Luncheon is made a movable feast; and exhaustion finally secures this meal at two and a half, three, three and a half, o'clock. After the proper

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five-hour interval is passed hunger ceases; but waste and exhaustion increase. When one is tired he cannot digest.

Our surgeon, or his house-surgeon, is laboring in responsible and wearying work after seven hours of fasting. Then he swallows food and has indigestion. It is true that the great elasticity of youth will bear this for awhile; but after thirty-five or forty years of age trouble comes.

But the physician's harvest time of labor is from forty to sixty years. At forty, perhaps, dyspspsia, flatulence, dilatation of the stomach, delayed peristalsis, pave the way for gastric ulcer, for pyloric obstruction; and possibly, later, for organic disease.

If now one seeks to brace up for delay and to take the support of alcohol, or to narcotize the hunger with tobacco, the cocktail passes directly to the liver and thickens Glisson's capsule; and the nicotine is expended on the nervous centers.

What a common history! Alas! too common.

There is nothing which breaks the health so certainly as irregularity in time (not quality) of eating, except the use of hard spirits in an empty stomach.

Wine, or beer, with meals is harmless, if in moderation; and tobacco after eating does a very minimum of harm; it narcotizes and congeals indigestion; but if used continuously it may functionally weaken the heart.

These are axioms; platitudes you will say: how much do they cost? Health, happiness, equanimity. Finally there is a breakdown. The physician at fifty is tired out, and needs a rest; not always from hard work, however, but from the insidious waste of irregular hours.

It is true that responsibility, anxiety also wear him; but they cannot wear out the healthy body.

Firm health and vigor shake off anxieties and responsibilities; health resists; health insures longevity.

But if the physician is so unfortunate as to take his cares to bed with him, he has mistaken his calling.

Wakefulness is fatal to equaminity. If the doctor cannot sleep after any night call he is sure to break down. The occasional loss of sleep from night work need, however, cause no anxiety. For

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sleep is so imperious a need, that all finally get it, if reasonably healthy. Forty-eight hours without sleep is followed by enforced sleep; nature takes care of that. People sleep standing up, and on horseback.

Next to regular food the physician needs open air. This he gets more than in other callings. He rides and rests as he rides, and even sleeps, if he does not drive himself. He had better not smoke as he rides.

Now, bodily exercise is much talked of. It is a relative term; for all do not need the same amount. I have sometimes thought and often felt, during my active period of work, that rest and not exercise was my first need. Hospital work, or private practice, four hours of the one, or ten visits of the other, are exercise enough. One is tired all over. While a little exercise in the open air will freshen up the exhausted tired feeling, much exercise fatigues too far.

As time goes on, and age increases and practice decreases, now is the period for systematic, determined exercise; in a gymnasium, walking, bicycling, riding a horse, rowing, playing light out-of-door games. Stiffening joints, sagging vertebræ, hardening of arterial coats are all loosened and their changes postponed by bodily exercise. Obesity should be discouraged; a lighter diet followed; exercise be increased.

The practice of medicine and surgery is a healthy occupation, compared with the legal or the mercantile life. There is constant mental pre-occupation; there is much to interest one; there is endless novelty and variety. It is all right for happiness and longevity, provided some simple rules are strenuously observed.

Such are regular meals, sleep enough, out-of-door exercise, occasional vacations. None of these can be absolute rules; but we must try for them.

Next to bodily health is peace of mind. Do not cry over spilt milk. Dismiss the inevitable past. You know you did the best you could. Say to yourself, "With the light I then had could I have done better?" No, you could not. Let it go; remember it only to guide the future.

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The doctor shares his patient's sufferings; true; be sympathetic, but do not let it go too far.

The healthy body now comes in again.

Phagocytes of worry-germs depend on good health for their vigor.

Health sheds all minor ills; is a tonic to brace up resolution; makes you feel a better doctor, and one more likely to cure your patient. For no one who has experienced a fit of sickness in his own person can forget how soon the mind sickens with the body. Courage fails; forebodings grow; judgment is annihilated. It is also a familiar remembrance that whenever we sleep, and the co-ordination of consciousness is lost, we dream, and a dream of insanity: real in imagination; unreal in fact; pleasant if we digest well; fearful if the solar plexus is compressed by a flatulent and dilated stomach.

Temperance governs our lives also. It is an inheritance; but it can be regulated and disciplined. Let us learn to do that, and remember that he who masters himself is greater than he who taketh a city.

Self-control, immovability, calmness, resolution, cheerfulness, health of mind, based, however, on health of body.

If there is one quality in our profession essential to success it is endurance or "staying power."

Many persons achieve a temporary success, but are unable to retain it. It is the long-winded man who wins the race.

This quality, even if inherited, must be cultivated; and this can only be done by physical training in youth.

Fortunate the young physician who starts in his profession with a deep chest and hardy limbs. In this way, sometimes, a country boy surpasses one city-bred, just as the fisherman outlasts the college oarsman. The one is tough all over, the other is strong in spots.

Early manual training may be regarded as an essential to success, as much as a technical education to cultivate the observing faculties.

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Tact is a gift of the gods. It is invaluable as an asset in life. And in our calling so much depends on personality and making a good impression, that tact is almost sure to out-speed other rivals.

Finally, we may truly say that calmness, good humor, pertinacity, staying power all lean on good health. The body is the ally and the indispensable backer of the mind.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

SAFE HYPODERMIC ANESTHESIA FOR MAJOR SURGICAL WORK IS NOW AN ACCOMPLISHED FACT.

From all sides come reports attesting the remarkable efficacy of the new method of securing surgical anesthesia with "Hyoscine, Morphine and Cactin Compound, Abbott." The surgeons are taking it up with something akin to enthusiasm. The writer had recently the opportunity of witnessing three serious operations performed under this anesthesia. One was an appendicitis. This patient had two injections of one tablet each two hours apart. After the last one the attendant came to report nervously that the respiration had fallen to six per minute! The surgeon got up leisurely and remarked that the patient was about ready for the operation, and without concern proceeded with the work. No nausea, no assistant to see to the anesthetic' no unrest, bronchitis or nephritis, but perfect anesthesia for hours, allowing plenty of time for careful work, with hours of quiet sleep thereafter. Surely this is pretty close to the ideal.

Several physicians have reported similar ideal results from this combination in obstetric cases. Smaller doses, however, are used (half size) and care should be taken not to begin too early. This combination is also the best we possess for false pains and pending miscarriage, especially from excess of fetal activity.

Other reports coming in indicate that the profession is applying this anesthetic combination in a wide range of other pointed cases. Several have testified to its superior efficacy in relieving the atrocious pangs of hepatic and renal colic, where it leaves the old morphine-atropine combination hopelessly in the rear. A few doses may also well be used to produce sleep in morphine cases, while the regular dope is being gradually reduced. This will probably prove efficient and safer than hyoscine alone. It

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is now an established fact that hyoscine, when chemically pure, is not therapeutically identical with scopolamine as some claim. Results unqualified by disprove their assertion. The triumph of this anesthetic "Hyoscine, Morphine and Cactin Compound, Abbott" is again a triumph for chemical purity and definiteness of drug application.—*Clinical Medicine.*

SOME NOTES ON THE DIAGNOSIS AND THE RESULT OF SURGICAL TREATMENT OF CEREBELLAR TUMORS.

B. Sachs declares that the question of the surgical removal of cerebellar tumors has given rise to considerable discussion. The difficulties of diagnosis are somewhat greater than those ordinarily met with in other intracranial neoplasms. The diagnosis is sometimes made by exclusion. Strictly localizing symptoms are less certain than they are in the cases of tumors affecting the motor or occipital areas. Other things being equal, rapidly advancing optic neuritis may serve as a symptom pointing to cerebellar tumor. The early development of unilateral or bilateral rectus externus palsy is to be given due weight. The writer regards this symptom as almost pathognomonic of cerebellar lesions if it is associated with the general symptoms pointing to increased intracranial pressure. As to treatment, he believes that when the diagnosis is made and when there is a fair degree of certainty as to the special part involved, a large trephine opening should be made over the suspected area. Even if the neoplasm is not found, much good will be done by the relief of pressure.—*Medical Record*, December 22, 1906.

LATE RESULTS OF THE X-RAY TREATMENT OF CUTANEOUS EPITHELIOMA.

Charles Mallory Williams presents a table of eleven cases of cutaneous epithelioma in which he has used the x-ray treatment. The writer says that the lapse of time even in the best of the cases, is too short to give absolute assurance of cure, but it is, nevertheless, long enough to establish a strong presumption of permanence, which is strengthened with every passing month. This hopeful outlook is favored also by the fact that

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the last recurrence, even in the insufficiently treated cases, was noted a year ago, since which time there has been no defection, save by death by independent causes.—*Medical Record*, December 8, 1906.

A CASE OF ENCYSTED VESICAL CALCULI.

In the case here reported the patient had suffered some four years, previous to having been seen by the writer, with a tight urethral stricture for which a very extensive external urethrotomy had been done, but the after-treatment had been badly neglected, the introduction of sounds after the operation and during the patient's convalescence scarcely having been used at all. As a result the urethra appeared, upon examination by the writer, to be the seat of extensive cicatricial stricture. The patient was suffering from frequent and painful urination both by day and night. There was no history of hematuria. The urine at the time patient was examined by the writer showed upon microscopical examination a large amount of pus, but no blood.

The patient being anesthetized, after patient effort it was possible to pass a Bank's filiform followed by an ordinary filiform bougie, upon which was threaded a tunneled sound which was finally made to enter the stricture. The membranous urethra was opened for a distance of half an inch upon the guide and the stricture freely cut, using the tunneled sound, and back of its point the filiform as a guide for the cutting with first a Gouley's beaked bistoury followed by the use of a probe-pointed bistoury. The neck of the bladder was then dilated with the finger, when a phosphatic stone was found of an inch and a half in diameter. This was crushed and the fragments washed away through the perineal incision.

High up in the floor of the bladder-wall could be felt a hard mass which was covered by mucous membrane and could be distinctly outlined with the finger in the rectum. After several efforts with a probe introduced along the finger it was possible to pass this instrument from the bladder through a small opening down into a space between the bladder and the rectum,

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within which space were two large calculi. Using the probe as a guide the bladder mucosa over the calculi was incised with scissors and the calculi removed with the greatest difficulty. It was apparently impossible, so firmly were they crowded into this cavity, to grasp them with forceps or get an instrument behind them for their removal. Finally, however, by the use of a small scoop one of the calculi was sufficiently dislodged to allow the use of the lithotrite, introduced through the perineal incision, sufficiently to partially break up the calculi and the fragments were removed with some difficulty with a scoop. The bladder was drained by a large soft-rubber perineal tube. —*The A. J. of Clinical Medicine.*

HÆMORRHOIDS.

Mr. C. J. Symonds, M. S., F. R. C. S. (Guy's Hospital Gazette; General Practitioner, November 24th), says in a clinical lecture: "I have no doubt whatever that pile operations are carried out much too extensively in many cases, often unwisely, and I would even add unnecessarily. Let it be remembered that many patients pass through a period of hæmorrhoidal trouble, obtaining complete freedom by careful attention to the bowels and altered habits o: life. In such patients remove, if necessary, any prolapsing pile and the rest may be left. Let me add that if you later adopt some such method as I have described above, [free and deep puncturing with the electric cautery] inject freely with the following solutions:

Beta eucaine	3 grains.
Sodium chloride	12 grains.
Distilled and boiled water	3½ ounces.

This is safer than cocaine, and is the formula adopted by Barker for the larger operations, such as radical cure of herina. You can use it for circumcision and promise the patient the operation will be painless.—*St. Louis Medical Review.*

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MEDICAL

THE SCOPE AND VALUE OF THE SANATORIUM IN THE ANTITUBERCULOSIS MOVEMENT.

Herbert Maxon King sums up his paper as follows: The sanatorium offers the tuberculosis invalid the most practical, indeed the only systematic, method of fighting his disease and acquiring hygienic education in its prevention. It is a most valuable educational factor, not only in the immediate community in which it is located, but to a very great extent in the community at large, and it has a definite and important place, which can scarcely otherwise be filled in the study and investigation of the disease and its complications. In these three relationships, then, the sanatorium possesses a scope and value of vital importance in the present great antituberculosis movement, and the writer believes that whatever the future may have in store for it, the sanatorium must always hold a place, and a vitally important one, in this great movement.—*Medical Record*, December 15, 1906.

PRURITUS ANI.

T. Chittenden Hill says that by far the most important causes of pruritus ani are superficial ulcerations or abrasions of the anal canal. This lesion is very constant and should always be looked for. The writer then discusses various other conditions associated frequently with this affection, among which are catarrhal diseases, hemorrhoids, and polyps. Appropriate treatment must be applied to the unnatural skin before much amelioration of the itching can be expected. After defecation the patient should cleanse thoroughly the anal region, preferably with absorbent cotton which has been wrung dry of some antiseptic solution. An anal pad held in place by a T bandage will protect the parts from friction and irritation of the discharge. Nitrate of silver and citrine ointment are excellent applications in most cases. For delicate skins the following ointment may

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be substituted for the citrine: red oxide of mercury, three drachms; Venice turpentine, one ounce; lanolin three oucnes. —*Medical Record*, December 22, 1906.

THE INTESTINAL BACTERIA; HOW THEY ACQUIRE TOXICITY, AND HOW TO DETERMINE THIS EXPERIMENTALLY FOR CLINICAL PURPOSES.

E. Palier declares that we have to deal with only two microorganisms, which are constantly found in the feces and which may become pathogenic. These are the coli bacilli and the cocci. From his experiments he concludes that a fresh medium enhances the virulence of the coli bacilli, and that in agar older cultures are on the whole more virulent than fresh ones. It appears that under a meat diet the coli bacilli of the intestines are most likely to become virulent. This is most likely to occur when some of the meat happens to pass in an indigested state through the stomach and duodenum. As to the cocci, the writer has found them usually in the form of diplococci or in short chains. It is generally admitted that the coli bacilli are in most cases responsible for appendicitis, yet in some cases cocci alone are found in this affliction. The presence in the feces of virulent cocci denotes a localized point of suppuration somewhere in connection with the intestinal canal. It is the virulence of bacteria that is of importance.—*Medical Record*, January 5, 1907.

ORGANIC HEART DISEASES AND IMMUNITY FROM PULMONARY TUBERCULOSIS.

Dr. Bond Stow, of New York (Amer. Jour. Med. Science, October, 1906), states that the central idea in his paper is that immunity in organic heart disease depends on long standing passive hyperæmia in the pulmonary circultaion. He believes that, by thus concentrating in the lungs the immunizing agents of the blood, the organism is protected from invasion by the tubercle bacillus. The great Louis, in France, was the first to call attention to the fact that stenosis of the conus arteriosus or the pulmonary orifice is occasionally followed by tuberculosis

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of the lungs. A review of the literature convinces Stow that pulmonary anæmia is favorable to the implantation and growth of the bacillus. Rokitansky first showed that cases of pulmonary stasis were rarely followed by tuberculosis. A review of the literature supports this view. Therefore, says Stow, practically it is of importance to produce artificially pulmonary congestion, and this can be done by exercise in the open air. This is especially valuable for incipient cases. In other cases one must be governed by the individual needs of the patient. He reports two cases with autopsies showing that organic heart disease has a very salutary effect on tuberculosis of the lungs. In both cases heart lesions were found, evidences of long continued pulmonary congestion and healed lesions of tuberculosis but in both cases were quite extensive.—*St. Louis Medical Review.*

DIGITALIS IN VALVULAR HEART DISEASE.

Colbeck says that digitalis should seldom, if ever, be given in cases of aortic regurgitation which has developed during or after middle life, since the ventricular wall is seldom perfectly sound under these circumstances, and never in patients who give evidence of myocardial degeneration or disease. If complete rest is obtained, digitalis is permissible and beneficial up to a certain point in young, otherwise healthy adults showing signs of circulatory failure, more especially when the aortic lesion is combined with mitral incompetence. The drug should be discontinued for some time before exercise is resumed, and this rule should be rigidly observed. Neglect of this precaution might be followed by rapid failure of the ventricle and sudden death. Theoretical considerations suggest that the utility of digitalis in aortic incompetence is strictly limited. It may be accepted as a good working rule that digitalis is beneficial in cases of aortic incompetence proportionally to the magnitude of the stress which has led to failure of the heart and *vice versa*. Colbeck says that digitalis is contraindicated in aortic stenosis apart from the appearance of cardiac failure. He endorses the use of digitalis in cases of mitral insufficiency, but in mitral

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stenosis he says that it can be of no benefit in the absence of failure of the right ventricle, and in this event, so long as the pulmonary blood pressure has been raised to the point at which the maximum charge of blood is delivered to the left ventricle, the drug will again act prejudicially.—*The Journal of A. M. A.*

HYOSCINE.

On account of the untoward symptoms which have been reported from time to time after the administration of hyoscine (scopolamine), Kessel (*Arch. Intern. de Pharmacodynamie de Therap.*, vol. xvi, p. 1, 1906), has investigated the action of specimens of different physical condition and of varying age upon frogs, rabbits and dogs. The physiological effect was the same whatever the optical activity of the specimen, as had been previously found by E. Schmidt in 1898. Also a solution over a year old was found to have retained its powers. The drug was tested by observing the dilatation of the pupil, the nacorsis, the blood-pressure, and the respiration. The individual reaction of the animal was productive of far greater variations in the results than any peculiarity of the sample of hyoscine used, especially with the more highly-developed creatures such as dogs. In reference to the use of this drug for operations, Kessel points out that though an animal in hyoscine narcosis may fail to notice the prick of a needle, yet the corneal reflex always remained. He quotes Voight as saying that even when combined with morphine in the proportions of one-half milligramme of hyoscine to ten milligrammes of morphine, it is only suitable for using as a preliminary to ether anesthesia. The great excitement and convulsions which have been observed occasionsionally are due to an impurity called "apoatropine," which may be detected as follows: A drop of potassium permanganate solution added to a dilute solution of hyoscine or of atropine suffers no change; but if apoatropine be present, even in the proportion of one in 20,000, reduction takes place to oxide of manganese, as is shown by a brown-yellow color.—*The Medical Age.*

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OBSTETRICAL

GLYCOSURIA OF PREGNANCY.

Many physicians in the past have become alarmed at the discovery of sugar in the urine of pregnant women. But it has been found that some women in perfect health become temporarily glycosuric during pregnancy. Here, then, as in other fields of medicine, the doctor must remember there is a difference between diabetes and glycosuria; but it must be admitted it is a most delicate matter to decide where the glycosuria of pregnancy ends and where true diabetes begins. One is a be nign and transitory affection in which no treatment is required, while in the other prognosis is grave; hence differentiation is extremely important. The most distinctive point is that in glycosuria of pregnancy the amount of urine is not increased. Besides, it is not associated with loss of flesh, with great thirst, or with morbid hunger (though this is sometimes present—from the "cravings" of pregnancy, not diabetes). Finally it disappears as soon as labor is ended—or rather as soon as lactation is established. In true diabetes of mild type gestation will go on to term in a normal way, but in the acute and subacute types, abortion or premature labor is to be feared. In the majority of cases of diabetes there is cessation of symptoms during the first half of gestation and then suddenly an aggravation of the pre-existing symptoms takes place. It is about this time that such accidents (especially hemorrhage) as are due both to pregnancy and to diabetes, arise; and then the prognosis becomes exceedingly bad.—*Clinical Medicine.*

ANEMONIN FOR DYSMENORRHEA.

Anemonin, a camphor derived from pulsatilla, seems to have a special field of action on the generative system; increasing power, relaxing spasm, and (when given near the menstrual period) producing a free flow. It may therefore be administered in those cases of dysmenorrhea accompanied by spasmodic

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pains, particularly when associated with a tendency to amenorrhea. It is best employed in the form of granule containing a half milligram (.0005 or gr. 1-34); one to be taken every half hour during the acute stage and one three times a day at other times.—*Clinical Medicine.*

VAGINAL DRAINAGE IN CHILDREN AND YOUNG ADULTS.

In the *Medical Chronicle* for May, A. W. W. Lea calls attention to the efficiency of this route in draining the pelvis of young children, and states that it is seldom used except in adults. Kelly, for example, in illustrating a case of abscess bulging into the pouch of Douglas, in a girl of ten years of age, says, "Vaginal drainage impossible, owing to age of patient." For some years Lea has employed vaginal drainage in children whenever it has been necessary to drain the pouch of Douglas, and the results have been satisfactory in every case. In some cases abdominovaginal drainage was used, in others vaginal alone. His cases number twelve, the ages being five to fourteen years, the affections being acute appendicitis and tuberculosus peritonitis.

The writer believes that vaginal drainage should be employed in all cases of diffuse peritonitis in children, for localized pelvic abscess if it can be felt bulging in the pelvis floor, and may be of value in tuberculosus peritonitis. The vagina of even a young child can be readily dilated to admit the finger, often without any abrasion or laceration of the parts. If abdominal drainage is also to be established, the tube may be drawn through from above. A piece of silk may be attached to the vaginal tube to permit of its withdrawal when necessary. The presence of the tube in the vagina causes no discomfort, and is well borne by even young children.—*N. O. Med. and Drug Journal.*

HETEROPLASTIC OVARIAN GRAFTING.

The Medical Record (May 5, 1906) contains a report of a case of a woman twenty-one years old, from whom Robt. T. Morris removed both ovaries completely, for cirrhotic ovaritis.

Just prior to this operation he removed a wedge-shaped ribbon of normal ovarian tissue from a patient being operated upon by

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Dr. H. J. Boldt, for uterine prolapse. The above mentioned ovarian tissue was put in saline solution at a temperature of 100° F., and kept at this temperature until the above mentioned ovariotomy was completed. Then a slit was made through the peritoneum of the broad ligament on either side, parallel with the oviduct. In each slit was placed a segment of the ovarian structure obtained from Dr. Boldt's patient. These grafts were secured by a single stitch. The patient made an uneventful recovery, and four months later menstruated for the first time in over two years. Four years later she was delivered of a normal child.

Dr. Morris took great care in removing the cirrhotic ovaries, and used Tuffier's angiotribe so as to be sure that no ovarian tissue remained. He believes this to be a well defined case of heteroplastic ovarian grafting, followed by menstruation and pregnancy.

CONTRIBUTION TO THE STUDY OF THE DIAGNOSIS AND TREATMENT OF ECTOPIC PREGNANCY.

Hiram N. Vineberg bases his article on fifty-three operative cases. The ages of these patients varied from twenty-two to forty-one years. Six had never been pregnant before. The writer gives the three cardinal symptoms of ectopic pregnancy as amenorrhea of longer or shorter duration, irregular uterine bleeding, and abdominal pain, Although the diagnosis of ectopic pregnancy is in some cases extremely difficult, in the vast majority of cases the condition can be detected by the medical attendant if he will keep his mind alert. The writer does not approve of the practice of purposely leaving a large quantity of blood within the peritoneal cavity. He believes that some of these patients are lost on account of undue haste on the part of the operator. All bleeding should be arrested before the abdomen is closed.—*Medical Record.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages, at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

AN APPRECIATED TRIBUTE.

Under the heading "A Noble Type" the following beautiful and eloquent compliment appeared recently in the editorial columns of the *Nashville Daily American*. We take great pleasure in reproducing the article for the benefit of our readers, and feel sure that they, with ourselves, will take off the hat in honest recognition of the tribute therein paid to our grand profession. It is refreshing for the hard worked, underpaid, often abused practitioners of medicine to realize, as he may from the lofty sentiments eloquently expressed in this article, that his work is now and then recognized and appreciated at its true worth.

"In the current issue of the *National Magazine* is a story in verse by James Ball Naylor. It is headed "Dr. John Goodfellow—Office Upstairs," and is said to be founded on fact. It is the story of a doctor, one of a type, not as common now, perhaps, as formerly, but which still exists—like Ian MacLaren's "A Doctor of the Old School," the lovable Doctor MacClure, who should be as immortal as Jean Valjean. The doctor of the story was charitable, generous, broad-minded, who gave much of his service to the poor, who was imposed upon by many, who seldom collected a fee, and who, when he died, left so little of this world's goods his lean old horse who had served him as faithfully as he had served his fellows, had to be sold, along with his few belongings, to pay his debts and funeral expenses. Among the many he had befriended and served were a few who mourned

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him as the citizens of the glen mourned Doctor MacClure, and these gathered together and determined to mark his grave in some way to indicate that they were grateful and held him in memory. Too poor to purchase a monument or even a tombstone, they fashioned a rude wooden cross and erected it at the head of his grave, and then cast about for some way to properly mark it. Finally they thought of his battered old sign that had swung for many years in front of his modest office, and they transferred it to the cross over his grave. It bore these words: "Dr. John Goodfellow—Office Upstairs."

That was notice that the good doctor had "gone aloft." It is said to be a true story. We hope it is. It is not at all improbable. There are many such. There have been many Doctor Goodfellows and Doctor MacClures, and they have ministered unto the wants of the sick and needy, the oppressed and distressed in cot and cabin on the mountains and plains, and in the glens and valleys—riding in the snow and rain, in the darkness and loneliness of the night, in the sunshine and in the leaden weather. Whether it be to attend the mother who passes through the shadow through which women are glorified, or to administer unto the infant or the aged, or to succor the humble bread-winner from sickness or the grave, or, when his loving skill has failed, to close the eyes of somebody's dear one when the light has failed, he is a faithful friend whose heart beats for humanity, and who lives to serve others in a noble profession which he honors. And when his time comes and he and Dobbins travel the lonely roads no more he moves his office—"upstairs." If we ever get to heaven we expect to meet Doctor William MacClure, Dr. John Goodfellow and many another country doctor who "made good" while on earth."

FOR THE CONSIDERATION OF THE LEGISLATURE.

An item of interest in Governor Cox's last message to the Legislature now in session is in reference to the establishment of a separate hospital for prisoners sick with tuberculosis. The importance of such an institution is easily manifest, and we trust

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the suggestion of his Excellency as expressed in his message may secure the attention it deserves from the Assembly and take definite shape in the passage of a bill to provide such separate accommodations for that menacing class of patients in the State prison. We quote herewith this clause of the message:

CONSUMPTION AT THE PRISON.

"Tuberculosis is prevalent in our penitentiary, and too many cases are developed there. One convicted of a crime and sent to the penitentiary should not be doomed to die of consumption. There should be a suitable place provided in which to confine and quarantine all convicts suffering from tuberculosis. This place should be as far removed as practicable from immediate contact with other convicts, and should be separate and apart from any hospital in which is confined convicts suffering from other diseases.

I took this question up with the Penitentiary Commissioners some time since, but on referring the question to the Attorney-General of the State, was advised by him that the Commissioners were not authorized to build such a hospital without a special appropriation for that purpose.

I therefore recommend that you appropriate a sufficient sum to build a hospital for tubercular patients, and that you direct that it be erected outside the walls of the main prison."

STATE BACTERIOLOGICAL LABORATORY.

The following extract from the daily secular press explains itself. The need of such a provision is obvious. It is to be hoped that action taken by the Legislature may result in the successful establishment of such an institution in order that the sanitary equipment of the State may be brought fully abreast with the needs of the times:

"J. W. Dashill, Secretary to the City Board of Health, has in accordance with instructions of the Board, sent a copy of the following resolution, which was unanimously adopted on Monday, to Dr. Albright, Secretary of the State Board of Health:

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"*Resolved*, That the Nashville Board of Health recognizes the need of and the incalculable benefit arising from the services of a State bacteriological laboratory for the use and benefit of the medical profession of the commonwealth and the citizens of the same, this Board urgently recommends and petitions the State Board of Health and our Legislature to establish the same as soon as possible, public good demanding it."

PURIFICATION OF SEWERAGE.

A valuable contribution to the literature on the disposal and purification of sewerage has just been issued by the United States Geological Survey as Water Supply and Irrigation Paper No. 185. Investigations on the purification of Boston sewerage with a history of the sewage disposal problem, by C. E. A. Winslow and E. B. Phelps. The volume of sewage discharged by modern communities is so large and the character of all kinds of sewage is always so objectionable that the so-called sewage disposal problem becomes, from the economic as well as the sanitary point of view, one of the most serious with which American cities have to deal. It is of vital importance to every community to secure such a disposal of obnoxious sewage as will avoid the creation of any insanitary focus or foci in the environment, or any infringement of the laws of hygiene and sanitation.

The investigations described in this publication were made at the Sanitary Research Laboratory and Sewage Experiment Station of the Massachusetts Institute of Technology under the direction of Prof. William T. Sedgwick. The station at which the work was carried on is situated on the line of the main trunk sewer of the south Metropolitan district of Boston at a point where it contains the sewage of about half a million people. At this station pumps were installed and tanks were constructed for tests of the various methods of sewage purification. The results of this work and the practical conclusions that have been drawn are given in Water Supply Paper No. 185, which may be obtained on application to the Director of the United States Geological Survey, Washington, D. C. These results are by no

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means applicable merely to large cities, but contain lessons of practical value to all communities having to deal with the ever present sewage disposal problem. The description of the experiments is preceded by a careful and elaborate historical review of the whole sewage disposal problem from its origin in the wide adoption of the water carriage system up to the present time, when that system has become practically universal. This interesting review cannot fail to be of the highest value to expert engineers, sewage commissioners and cities all over the United States, especially to those numerous small communities that are confronted, perhaps for the first time, with a problem that means so much for the health as well as the finances of the citizens.

Physicians who are interested in the study and legitimate practice of the physical (drugless) therapeutic methods, notably, electro-therapy, photo-therapy, mechano-therapy, hydro-therapy, suggestion and dietetics, are invited to join the American Physio-therapeutic Association. Address the Secretary, Dr. Otto Juettner, No. 8 W. Ninth St., Cincinnati, Ohio.

The officers for the ensuing year are:

President, Dr. H. H. Roberts, Lexington, Ky.

Secretary, Dr. Otto Juettner, Cincinnati, Ohio.

Treasurer, Dr. Geo. H. Grant, Richmond, Ind.

Executive Council, Drs. W. F. Klein, Lebanon, Pa.; Jas. Hanks, Brashear, Mo.; J. W. Unger, West Point, Miss.; Chas. S. Northern, Talladega, Ala.; R. W. Gibbes, Columbia, S. C.; S. J. Crumbine, Topeka, Kan.; F. L. Keeler, Perry, Okla.

NEWS ITEM.

For the enlargement and betterment of the *Oklahoma Medical News-Journal,* beginning with the January, 1907, issus, the *Oklahoma Medcial News-Journal* will have a new editor, Y. E. Colville, B. S., M. D., of Chattanooga, Tenn. Dr. Colville has bought a half interest in the *Journal* and will devote his entire time to the editorial department, while Dr. Phelan will be the business manager. In this way the *Journal* will be greatly benefited and enlarged, and will be much more valuable to the profession than heretofore.

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Reviews and Book Notices

A Practical Treatise on Materia and Therapeutics, with especial reference to the clinical application of drugs. By John V. Shoemaker, M. D., LL. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital; Member of the American Medical Association and the British Medical Association; Fellow of the Medical Society of London, etc., etc. Sixth Edition. Thoroughly Revised. (In conformity with Latest Revised U. S. Pharmacopœia, 1905.) Royal Octavo, 1244 pages. Extra cloth. Price, $5 net. Full sheep. Price $6 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

The timely appearance of this excellent work in its sixth edition close upon the new revision of the United State Pharmacopœia will be welcomed by those of the profession familiar with its merits. The work has undergone in accordance with recent changes complete and thorough revision and though necessarily amplified by additions has been systematically condensed so that it is not materially increased in bulk. The author is well known as an author and needs no encomiums from us. The work is classical and ranks high as an important member of the class text books of the present day. We conscientiously recommend the work to students and practitioners.

Lea's Series of Pocket Text-Books—Diseases of Children. A Manual for Students and Practitioners, by George M. Tuttle, M. D., Attending Physician to St. Luke's Hospital, Martha Parson's Hospital for Children; Bethesda Foundling Asylum; and Professor of Therapeutics, Medical Department of Washington University, St. Louis. Series edited by Bern N. Gallandet, M. D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, Columbia, University, New

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York; Visiting Surgeon Bellevue Hospital, New York. Second Edition, Revised and Enlarged. Illustrated with five Plates in Colors and Monochrome. Lea Brothers & Co., Philadelphia and New York.

This is the second edition of this popular pocket text-book series. It is designed to meet the requirements of the beginner in the study of pediatics. The subject is covered fully and yet is presented in concise form, special attention being paid to the physiology of infancy and artificial feeding. It is not only an admirable guide to the student, but a trustworthy work of reference for the practitioner of medicine. In this edition a few more subjects have been introduced and the whole text modified in accordance with recent advances and improvements in this important department of medicine.

A TEXT-BOOK OF HISTOLOGY—By Frederick R. Bailey, A. M., M. D., Adjunct Professor of Normal Histology, College of Physicians and Surgeons, Medical Department, Columbia University, New York City. Second and Revised Editon. Profusely Illustrated. New York. William Wood & Co. 1900.

In the second edition of this work we are sure the student will find a text-book admirably suitable to his needs in this rather difficult department. As a manual for reference to the student, and for class-room teaching for the instructor it is excellent. The chapters on the nervous system are better than usual and are exceptionally valuable. The second edition of the work has undergone such changes as serves to bring it fully up with the most recent advances. The work is very meritorious and will doubtless in this edition receive even more extended welcome than was accorded to the first.

MEDICAL GUIDES AND MONOGRAPH SERIES.—Golden Rules of Pediatrics Aphorisms; Observations and Receipts on the Science and Art of Pediatrics, giving Practical Rules for Diagnosis and Prognosis; the Essentails of Infant Feeding, and the Principles of Scientific Treatment, by John

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Zahorsky, A. B., M. D., Chemical Professor of Pediatrics, Washington University, Medical Department, St. Louis; Ex-President of the Bethesda Pediatric Society; Attending Physician to the Bethesda Foundling's Home; Member of The American Medical Association, and of the St. Louis Academy of Science; Editor of the St. Louis Courier of Medicine; Author of "Baby Incubation," etc. With an introduction by E. W. Saunders, M. D., Professor of Diseases of Children and Clinical Midwifery, Washington University, etc. St. Louis. The C. V. Mosby Medical Book Co. 1906.

This little volume serves as a guide to physicians and to young mothers. The knowledge it contains is well arranged and accessible. The field the text covers is extensive. As an aid to the profession it possesses many merits. We take pleasure in commending the work.

STENHOUSE AND FERGUSON'S EPITOME OF PATHOLOGY.—By John Stenhouse, M. D., of the University of Toronto, and John Ferguson, M. D., Toronto, Canada. 12mo., 285 pages, amply illustrated. Cloth, $1.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906. (Lea's Series of Medical Epitomes. Edited by Victor C. Pedersen, M. D.)

We are pleased with this epitome, belonging to the well-known series and presume that the manual will give satisfaction. It is admirably arranged and carefully epitomized. As an aid for the student it is unexcelled. It is wonderful how knowledge can be compressed in such compact form.

PROGRESSIVE MEDICINE.—A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, etc. Assisted by H. R. M. Landis, M. D., Visiting Physician to the Tuberculosis Department of the Philadelphia Hospital, to the White Haven Sanatorium and to the Phipps Insti-

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tute; Demonstrator of Chemical Medicine in the Jefferson Medical College. Volume IV. Dec., 1906. Diseases of the Digestive Tract and Allied Organs; Liver, Pancreas, and Peritoneum; Anesthetics, Fractures, Dislocations, Suppurations, Surgery of the Extremities, and Orthopedics, Genito-Urinary Diseases, and Diseases of the Kidneys. Practical Therapeutic Referendum. Lea Brothers & Co., Philadelphia and New York, 1906.

A very interesting number of this important quarterly. It contains "Diseases of the Digestive Tract and Allied Organs, by J. Dutton Steele, M. D. "Genito-Urinary Diseases," by William T. Belfield, M. D.; "Diseases of the Kidneys," by John Rose Bradford, M. D.; "Anesthetics, Fractures, Dislocations, Amputations, Surgery of the Extremities, and Orthopedics," by Joseph C. Bloodgood, M. D.; and "Practical Therapeutic Referendum," by H. R. M. Landis, M. D. The physician who wishes to keep fully up with the times should by all means subscribe to this quarterly publication.

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Publisher's Department

A Sheet Anchor in Pneumonia.

BY S. W. UMSTOT, M.D., HAGERSTOWN, MD.

Two years ago I began the use of Antiphlogistine in the treatment of pneumonia, and it has proved my "sheet anchor" ever since. My custom is to make daily applications, and by using it in this way I am able to hold the disease in check. Antiphlogistine reduces the inflammation without reducing the patient's strength, and owing to its many virtues is strongly to be recommended as an adjunct in the treatment of pneumonia.

A few cases follow:

Mrs. G.—Was called January 28, 1905. An examination proved lobar pneumonia, in the upper lobe of the right lung. I applied hot Antiphlogistine and the cotton jacket. Next day the patient was doing well. I renewed the dressing daily for four days when it was discontinued, as the necessity for its use had passed away. The recovery was uneventful.

Mr. K.—Was taken ill April 12, 1905, with his second attack of double pneumonia. I at once applied Antiphlogistine and a cotton jacket, and renewed the dressing daily. In two weeks he was sitting up, and he made an uneventful recovery.

Mrs. D.—A woman with a tubercular diathesis was stricken with pneumonia of the right lung December 4, 1905. Antiphlogistine and the cotton jacket were used as in the preceding cases. I discontinued my calls in twelve days, after a complete cure.

Mrs. S.—Was called February 22, 1906, and found double lobar pneumonia. Applied Antiphlogistine, hot, then daily until the eighth day when the crisis was passed. Antiphlogistine was of inestimable assistance in this case.

Mr. A.—45 years' old. I first saw the case April 22, 1906; found a double lobar pneumonia with pleurisy of the left pleura. I at once applied Antiphlogistine as hot as could be borne, and

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used it daily for twelve days. On the sixth day the evening temperature registered 105.80. The temperature dropped by lysis, and he made a good, although slow recovery.

HEMORRHOIDS.

BY ELMORE PALMER, M.D., EX-PRESIDENT OF THE WESTERN NEW YORK MEDICAL SOCIETY, BUFFALO, N. Y.

Without any comment on the nature, causes, varieties or pathological conditions found existing in rectal ailments, I will transcribe from my records two cases of hemorrhoidal trouble that I have treated within the last two years with Glyco-Thymoline:

Case 1.—Mr. B. O. H., age 29, had been ailing several years with what he called piles. A careful examination revealed the following condition: On the margin of the anus were three strangulated tumors about the size and color of a Concord grape. On continued pressure the tumors would empty themselves almost entirely, but refill again in the course of an hour. Several similar tumors about the size of a pea were found just inside the sphincter. Anal moisture and pruritus were very troublesome, but singularly enough little pain was complained of. The bowels were somewhat constipated. Regulated the diet and secretions, gave an enema of two ounces of a fifty per cent. solution of Glyco-Thymoline every night and morning quite warm, held in until absorbed, and applied gauze to anus on lamb's wool during the night, and as much of the daytime as he could spare from his office. A decided improvement was noted in aweek, and three weeks later he was cured. That was nearly two years ago, and there has been no trouble since.

Case 2.—Mrs. R. consulted me regarding "bleeding piles," which had been gradually growing worse for three or four years. At every stool she would bleed two or three tablespoonfuls. She had become quite anemic. No external tumors. A corroding ulcer as large as a nickle was diagnosed just inside of the internal sphincter. Washed out the rectum three times a day at first with a warm solution of boric acid and then gave an enema of one

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ounce of Glyco-Thymoline full strength hot, held in until absorbed. After four doses only two enemas a day were used, as no blood was passed. At the end of two weeks' time a careful examination of the rectum showed it to be perfectly normal. She was cured. No return after eight months.

The use of good hypophosphites in pulmonary and strumous effections is generally agreed upon by the profession. We commend to the notice of our readers the advertisement on page 63 of this number. Robinson's Hypophosphites, an elegant and uniformly active preparation; the presence of quinine, strychnine, iron, etc., adding highly to the tonic value.

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Original Communications

PRACTICAL THERAPEUTICS.

BY E. S. MC KEE, M. D., CINCINNATI.

Pruritus.—Intense and stubborn itching, according to Besnier (*Journal de Medicine*), is relieved by one half per cent. solution of phenic acid in glycerole or starch.

Odorous perspiration is successfully relieved by subnitrate of bismuth, one ounce; permanganate of potassium, three drachms; powered talc, one and one-half drachms; powered rice, two ounces. Dust well with a piece of cotton twice daily.

For Coughs.—Quit prescribing proprietaries and use the National formulary: Elixir terpin hydrate, N. F., contains one grain of terpin hydrate to the drachm. Elixir terpin hydrate cum codeina contains in addition, one eighth of a grain of codeia to each drachm. Elixir terpin hydrate cum heroin, N. F. contains 1-24 grain of heroin to each drachm. Mistura pectoralis, Stokes N. F., contains one grain per drachm of carbonate of ammonia, with senega, squill, paragoric and syrup of tolu, and makes a very efficient combination.

Guaiacol 10 to 15 per cent, in petrolatum of lanolin makes a very efficient ointment for rheumatism, sciatica, arthritis deformans, orchitis and epididymitis.

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Lime in the eye will be well remembered if you have once had it. See if you can remember that the quickest relief is a solution of sugar in vinegar. The sugar forms an insoluble compound with the lime. A few drops should be introduced and the eye washed with plenty of water.

For the Cough of Lobar Pneumonia.—Dr. John V. Shoemaker finds that he gets much relief by administering internally every two hours till relieved, then every four hours, the following mixture:

℞ Codeinae sulphatis, grain 1-8 or 0.008.

Ammoniae chloridi, grain iii or 0.18.

Spirit juniperis compound, m. X. or 0.65.

Mist glycyrrhizæ compound.

Syrupii prunii virginianæ aa oz. or ss or 15.00 m. for one dose.

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Headache Remedy in Liquid Form.—Some patients will have their medicines in liquid form and, the following is the solution of a good headache remedy: Acetanilide, 4.00; alcoholis, 15.00; ammoniæ carb., 2.00; aquæ, 8.00; elixir adjuvantis q. s. ad., 60.00. M. S. Teaspoonful every one, two or three hours, as necessary.

Common Colds.—Atkinson (*B. M. J.*) gives a very common combination for the cure of this common, but uncommonly hard to cure complaint: ℞. Spiriti ammoniæ aromaticæ, 30; Sp. æther nitrosi, 30.00 M. S. One teaspoonful in an ounce of water to be repeated in two hours, then continued every 4 hours. If mucus quite thick, snuff with cocaine, 1.00; menthol, 2.00; acid boracic, 100.00.

Perineural Infiltration in Sciatica.—Crossmans experience in the Wieden Hospital in Vienna, is to the effect that this method is no absolute cure, but that combination with other treatment methods, especially thermo-therapy, proves of benefit. It is of much value as a pain stillor—Wiener Klinische Wochenschrift.

Polliantin in Hay Fever.—Zarniko (*Berlin Klin. Wochenschrift*) reports 492 cases of hay fever with the remarkable result under polliantin of complete relief in 61.3 and 23.1 per cent. without result; 15.6 per cent. still under treatment at the time of the report. The cases without result are often on account of

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the irrational use of the polliantin. It must be used prophylactically one week before the expected onset of the attack.

Chloroform Narcosis as a Cure for Whooping Cough. —Rotschild and Brunier (*Bull. Memorabilien de la societe des hosp*). Narcosis to complete relaxation of the muscles with preserved corneal reflex not longer than from five to ten minutes is recommended. The choloroform narcosis acts through a sedative working on nerves to the spinal cord. The chloroform not only acts as sedative, but also during its passage through the respiratory apparatus as local antiseptic.

Nervous Dyspepsia.—Einhorn (*Denver Medical Times*) says that our main object should be to systematically increase the amount of food. Milk and its derivatives, kumyss, matzoon, clabber, buttermilk, cream, taken between meals play a prominent part.

Epistaxis.—℞. Adrenalin choridi gr. ss or 0.03; acid boracici gr. xlv or 3.00; aquæ cinnamomi, equæ camphoræ aa dr x or 150.00; aquæ dest qs ad oz. iii or 90.00. M. S. Instil a few drops into the nostril with a dropper.—*Medical News.*

Gunpowder Stains.—Moore (*Eclectic Medical Journal*) successfully removed all marks of gun powder from the forehead nose and chin of a man whose gun had exploded. He used pure phenol, applied with a sharp piece of wood, so as to cover each speck and destroy the tissue incasing the grain of powder. The patient was instructed not to remove the crust which formed, till the tissues beneath had healed. The application was not very painful, but a cooling lotion of camphor, menthol and albilene was found useful.

Salicylic Acid in Cholelithiasis.—Stiller (*Wien. Med. Woch.*) and Chauffard (*Berlin Klin. Woch.*) find this remedy of decided value in this condition. It is given between the attacks in doses of one-half gramme four times daily: 15-100 grain extract of belladonnæ is usually added. The medication is continued for three or four weeks, hot applications being made over the liver for two or three hours every morning and evening. It is said to have about the same effect as a course at Carlsbad, providing the salicylate is dissolved in warm Carlsbad water.

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Sciatica.—Potassii iodidi iv or 16.00; sodii salicylatis dr vi or 24.00; tinc. cimicifugæ; syr. sarsaparilla compositæ aa oz ii or 60.00; aquæ q s ad oz vi. M. S. One teaspoonful in water after meals. Indicated in rheumatic subjects.—*The Prescription.*

Diarrhea immediately after Eating.—Osler (*Denver Med. Times*) says correct diet, rest for an hour after meals, give bismuth one-half to one drachm t. i. d. for abnormal conditions in the small intestines, or napthaline preparations, then to fifteen grains four or five times per day.

Flatulent Dyspepsia.—℞. Creosoti m iii or 0.18; tinct. cardamon comp. m xv. or 1.00; syr. aurantii dr. ss or 2.00; aquæ q. s. ad oz i or 30.00. M. S. To be taken at one dose and repeated three times a day.—*Medical Bulletin.*

Infectious Diarrhoea in Adults.—℞. Hydrogeni dioxidi dr vi or 24.00; aquæ dest oz iiiss or 100.00; syr. dr. iv or 10.00.—*Revue Francaise de medicine et de chirurgie.*

Cough of Influenza.—The *Clinical Review* is authority for the following which it says acts like a charm: ℞. Benzol m x or 0.65; tinc. aurantii m xxx. or 2.00; spiriti chloroform m xv, or 1.00; tinct. senegæ dr i, or 4.00; aquæ q s ad oz i or 30.00. M. S. To be taken every four hours between meals. The senega makes a good emulsion with the benzol and other tinctures and the mixture is less unpleasant than when made with mucilage. Although it is unpalatable if patients can be persuaded to once take a dose or two they will learn of the benefit it is and continue to take it. It is imperative that the benzol should be absolutely fresh and colorless, since it rapidly undergoes decomposition, and gives rise to symptoms of intoxication with the appearance of an erythematous rash.

Hyperidrosis Pedis.—The following method is recommended in the *Journal de Pharmacie*: A one per cent. solution of permanganate of potassium is used which every three days is increased by one per cent., until in about 14 days, a six per cent. solution is employed. The foot bath is used once daily in the evening and at a rather warm temperature, 40 deg. C. (104 deg. F.). The duration of the bath is 15 minutes, after which the feet are allowed to dry without rinsing or wiping them. Morn-

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ings feet are to be dusted with: ℞. Potass. perman. 13.00; alumina, 1.00; talki, 50.00; zinci oxidi, cretæ pulv. aa 178.00. M. fiat pulvis. Small wads of absorbent cotton are placed between the toes. Stockings must be changed daily. Cure usually required 14 days. The treatment is free from pain and danger and can be carried on at any time.

TULASE, BEHRING'S NEW REMEDY FOR TUBERCULOSIS.

Tulase, the new tuberculosis remedy of Behring, in a pure state is a clear liquid resembling thin honey, which contains all the constituents of the Koch bacillus. Behring (*Pharmazeutische Zeitung*, 1906, page 966) divides these constituents into three principal groups: (1) Lipoid substances such as neutral fats and waxes soluble in alcohol, ether, acetone, chloroform, etc., including also all the substances insoluble in acids; (2) those protein compounds which are extracted from the defatted tubercle bacilli with distilled water and with 10 per cent. sodium chloride solution and which consist partly of nucleoalbumins and partly of globulins; (3) the proteids which form the principal constituents of the tubercle bacilli which have been freed from fats and from protein. The preparation of tulase, which is a very complicated process, embraces the treatment of the bacilli with chloral, by which the TC (an active constituent of the bacilli, so called by Behring) of the bacilli is so changed that when the tulase is administered either by way of the stomach or by subcutaneous or intravenous injection the cells of the TC are decomposed and converted into a hypothetical substance TX. This confers immunity against tuberculosis and against hypersensitiveness to Koch's tuberculin. Tulase is furnished only to such clinics as have physicians who are well grounded in bacteriology and who have studied for at least three months in the Marburg Institute for Experimental Therapy with a view to experimental work in the immunizing therapy of tuberculosis. Since the dosage of the tulase, the best method of application, the indications for its use, etc., are not yet definitely determined, the remedy is furnished without cost to such clinics as come within the above category. The physicians studying at Marburg are required to follow

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closely the methods laid down at Marburg as to registration of observations, the dosage, the method of application, the selection of the patients to be treated and the furnishing of regular reports. In the treatment of animals which have already been infected intravenous or subcutaneous application is recommended. The dose is given by Behring as 0.01 cc., which may be doubled at the second administration after a lapse of four days. After a lapse of two to four weeks the dose is again repeated, the same quantities being given with an interval of four days between. Tulase is put up in glass tubes, each containing 5 cc. of either 1 or 10 per cent. solution. It is stated that tulase can be used as a substitute for tuberculin in the diagnosis of suspected cases of tuberculosis. In view of the extravagant expectations which are entertained of the results which may be achieved from the use of tulase, Behring has in several addresses particularly warned his hearers against a tendency to expect too much of the preparation. He has said that the most that could be hoped for as a remedy is that by its early use young individuals may be protected from pulmonary tuberculosis. It is not to be expected that it will heal in cases where the lung tissues have already been destroyed by the ravages of the bacillus.—Through the *American Druggist* and *Pharmaceutical Record.*

Non Repetature.—In answer to a question as to the effect of the request on a prescription that it be not repeated, the *Journal,* of the American Medical Association replies as follows: "The prescription is an order on the druggist to furnish the patient with a certain medicine prepared in a certain way, and of a definite quantity. If the order incorporates the directions that the prescription be not repeated, the druggist has no right to refill it. This much appears to be reasonable and, we believe, legally correct. It is important in the interest of the patient himself as well as the physician, that the prescription be not repeated, since it frequently consists of a remedy appropriate only to temporary conditions which may have disappeared before the request for repetition is made and may possibly contain drugs, the continued use of which may produce a drug habit. The druggist not only

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ought not to refill the presription, but he ought not to give a copy, as this would defeat the object of the prohibition of the prescripti repetition. The prescription may be copied before it is delivered to the druggist.

Orphan Proprietary Medicines.—The committee on proprietary goods of the Northwestern Druggists Association, has devised the above expressive term to designate a class of proprietaries whose manufacturers have gone out of business, or otherwise neglected their product. These goods have brought out some complications in the administration of the new pure food and drug law.

The Treatment of La Grippe.—Nammack, in the *Medical Record* finds the symptoms which cry aloud for relief to be depression and respiratory catarrh. He usually meets these symptomatic indications by a prescription containing five grains of ammonium carbonate, five grains of ammonium salicylate, in a half an ounce of aromatic wine of erythroxylon coca, N. F. to each dose. This will relieve headache, neuralgia and stimulate the heart, respiration and kidneys.

Nuclein.

The *Modern Materia Medica* says: Nuclein as in vogue in this country is nucleinic acid derived from yeast, generally contaminated with some albumin and carbohydrates of the yeast cells. It occurs as a grayish- white, amorphous power, soluble in dilute alkalies, slightly soluble in water, and insoluble in alcohol or ether. It acts as a germicide, and increases the white corpuscles of the blood. It is used in tuberculosis, chronic ulcers, puerperal fever, etc.—per os in capsules or solution (2 to 4 grains three times a day, between meals) or subcutaneously in 5 per cent. solution in alkalinized water (10 to 60 minutes diluted with the same quantity of physiological salt solution freshly boiled). For hypodermic use a special, albumin-free article only is eligible. Marketed also in 2-grain casules, and in 5 per cent, solution for oral and for subcutaneous uses. (According to Dr. Vaughn, quinine,

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the coaltar antipyretics and atropine are contraindicated during nuclein treatment.) Trillat has prepared nuclein compounds of mercury, iron, manganese, vanadium, silver, arsenic, iodine, bromine, and fluorine.

Rapid Cure of Scabies.

The cure of itch in an hour and a half is said to be attainable by the method practised by Saboureaud (*Bulletin general de therapeutique,* November 30, 1906). The patient is first rubbed for half an hour with black soap (green or soft soap); he then takes an alkaline bath for half an hour. After coming out of the bath the entire surface of his body is to be well rubbed with:

℞ Oil of verbena and gum tragacanth..aa 1 part
Precipitated sulphur .....100 parts
Glycerin .....200 parts

To be well mixed.

A final bath is then to be taken, lasting from fifteen to twenty minutes. The clothing and body linen must be disinfected. During the fortnight succeeding this treatment four baths of starch water are given. In case there should be cutaneous iritation, local applications of ointment of zinc oxide are used.

The Coated Tongue.

L. Kast (*Interstate Medical Journal,* September, 1906) says that the examination of the coated tongue as an index to gastric disorders, upon which formerly so much stress was laid, has now generally fallen into disrepute. This is probably chiefly due to the lack of evidence that the conditon of the stomach can affect that the tongue, either by the direct ascent into the mouth of stomach contents (in the absence of regurgitation, eructation, or vomiting) or otherwise. Kast, however, has shown that such a process actually does take place. A number of patients, all of whom were free from regurgitation, eructation, and like, were made to swallow capsules containing lycopodium powder. The mouth was rinsed with water that same evening, and again the next morning. In over half the cases the mouth was found to

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be free from lycopolium in the evening, but to contain it next morning. The conclusion may fairly be drawn that in some cases stomach contents may gradually wander up the œsophagus into the mouth and form a coating on the tongue. In these cases the condition of the tongue may fairly be assumed to represent that of the gastric mucosa.

Disguising Disgusting Drugs.

The erudition of Egypt, the grace of Greece, the riches of Rome will not enable the average boy to take an undisguised dose of castor oil, quinine or salicylic acid without giving an exhibition of very bad taste. In these days of elegant pharmacy, Homeopaths, Osteopaths, Christian Scientists and "sich" it behooves us to try to make some very worthy remedies, which are as bad as they are good, more acceptable to the palate of the precocious youth and aged of our clientele. Some disagreeable drugs under some circumstances must be given in liquid form, and to render their administration less unpleasant in this form is the object of this short paper. It was Oliver Wendell Holmes who said: "Youth fades, love droops; the leaves of friendship fall." He might have added that the taste of some old reliable remedies outlives them all.

Quinine, a most valuable drugs, cannot be well given to children and infants in pill or capsule form, also in some cases of adults where the digestion is bad it must be taken in solution. The taste is very bitter. Quinine sulphate, one grain to three of tannic acid, can be given very well in syrup of tolu. Quinine sulphate, 1.00;glycerin, 2.00; fluid extract of yerba santa, 2.00; syr. cacao, ad., 30.00 M. S. Shake. Mix quinine, two or three grains to a drachm of olive oil and administer in cold milk. Quinine sulp., 0.65; aquæ (acidulated), 5.00; mellis albæ, 40.00.

M. Sig.—Drachm one every two or three hours. Quinine chocolates are a very good way to give the drug to children who can be persuaded to eat them. The taste at first is disguised, but generally appears later.

Salicylic Acid: This nauseous, sickening dose is best given

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in the salicylate of soda and well diluted. It is still bad, and some delicate stomachs cannot bear it at all. It is well given in the essence of pepsine or the elixir of lactopeptine, both of which obviate to an extent its deleterious effect on th stomach. Salicylate of soda is also well borne and its taste well concealed in equal parts of glycerin and syr. rubii idæ, equal parts of peppermint water and simple syrup or simple elixir also help disguise the evil taste of the salicylates.

For adhesiveness, viscidity and nastiness all;
For the most staying taste, give us castor oil.

Rinsing the mouth and throad with alcoholic liquors prevents the adhesion to those parts. It may be rendered more tasteless and less viscid by mixing it with hot milk, bouillon or coffee, or with the foam of ale or beer, or peppermint water and brandy. A small quantity of anisette in a claret glass, taking care that the edges of the glass are moistened with the liquor. The dose of the castor oil slightly warmed to make it thinner and more easily swallowed is poured into the glass. The penetrating odor of the cordial masks those of the oil, and it is hardly tasted when swallowed. The Arabs administer castor oil as follows: Pour an ounce of castor oil slowly, drop by drop, into a cup of milk set on a stove, and heat while stirring. In a few minutes a perfect emulsion is formed, and to this is added some syrup of orange flower. In this way the oil seems not only more palatable, but more active. The taste of the oil is scarcely perceptible when administered with glycerin and a few drops of cinnamon and oil of gaultheria. Administered in capsules the taste is, of course, quite covered, and this is a very good way, admissibly only for those who can swallow so large a capsule, and generally inadmissible for children. Sassafras in the preparation known as sarsaparilla is quite efficient in masking castor oil, especially when used in connection with effervescent waters. There are numerous other aromatics which could probably be used in the same way. It can be taken floated upon soda water flavored with some aromatic syrup, or a regular emulsion may be made, as with cod liver oil, by means of mucilage or other emulsifying agent. If thoroughly emulsified with the addition of orange juice, a mixture is formed which is al-

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most unobjectionable. Castor oil may be administered by rectal injection. In this way it acts principally locally, and mechanically as a lubricant, but there is doubtless a certain quantity absorbed, as there is usually an effect more than would otherwise be expected. Castor oil is absorbed to a slight extent through the skin, but this is of no practical value. Make a powder composed of equal parts of gum acacia, licorice, lactose and flavored with vanilla. A pinch of this powder added to water and shaken makes a very persistent froth, in which may be given, without the slightest taste, such oils as castor oil, as well as much lighter substances, salicylates, cod liver oil, iodized or phosphated oil, as of methyl, essence of santal, and so on.

The following are good formulas:

℞ Ol. ricini .....℥j
Glycerin .....℥j
Ol. gaultheriæ .....gtt. xv

M. Sig.—Take one to four teaspoonfuls.

℞ Vanillin .....gr. 1¼
Ol. menth. pip. .....gr. iv
Saccharin .....gr. ivss
Alcoholis .....℥iss

Mix and add:

℞ Tinct. cudbear .....gtt. xv
Ol. ricini .....℥iv

Mix, shake and add the above two mixtures together.

℞ Gum acaciæ pulv. .....℥ss
Ol. ricini .....℥j
Saccharin .....gr. x
Ol. cloves .....gr. ij
Aquæ .....ad ℥ij

Add the gum in the water; add the oil, and last of all, the flavoring:

℞ Saccharin .....gr. ij
Ol. menth. pip.....gr. ivss
Alcoholis .....q. s

M. fiat solution et adde ol. ricini ℥viij. Dose, same as castor oil.

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If your guts get in a coil,
Take a dose of castor oil.
19 West Seventh street, Cincinnati, Ohio.

Therapeutic Tips.

Thymol in Abscesses.—This remedy is very insoluble under ordinary circumstances, but dissolves in oil of eucalyptus when it becomes a valuable aid in the treatment of abscesses, especially the mild forms of chronic blind abscesses.

Corrosive Sublimate Applied Without Pain.—Appleman (*American Medicine*) states that when solutions of mercuric bichloride are made with normal salt solutions instead of water, they do not cause the slightest pain when applied to the mucous membranes.

To remove coating from instruments which have been boiled, prepare chalk, ammonia, alcohol aa 2 parts, water 4 parts. Rub the instrument with a cloth saturated with this solution, then rub them dry with another cloth.—*Dental Cosmos.*

A good local anesthetic for spraying abscesses before lancing, is made with ether and chloroform, 16 to 1.

Pleurisy Treated by the Injection of Gas.—Vaquez, at the meeting of the Societe Medical des Hospitaux, said that this was done with a double end in view; either of inhibiting a tuberculous process, or of treating the infusion itself. In acute pleurisy the duration of the disease is abridged, and in case of recurrence the gas injection was the treatment of perference. Nitrogen gas is prefered, as it is not absorbed too quickly, is not injurious, and remains a long time in the pleural cavity. The author was able to demonstrate its presence eight months after the injection. The amount to be used was variable and ordinarily equaled about half the quantity of fluid removed.

Guaiacol.

For exudative pleuritis and rheumatic joint affections the local application of a ten per cent ointment of guaiacol and salicylic acid gives excellent results. Fluids that have persisted for weeks

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melt away by this application. Pure guaiacol may cause too much absorption, but in a ten per cent. ointment this is not the case. One disadvantage to the ointment is that a few applications tan the skin like parchment. When possible apply in a new site each time.

Scopolamine and Hyoscine.

PROF. JOHN URI LLOYD, CINCINNATI.

History and Chemistry.—Scopolamine, the alkaloid recommended by Dr. Schneiderlin, was extracted by Schmidt, of Marburg, from the *Scopolia Japonica,* a perennial, herbaceous plant of the natural order Solanaceæ, popularly known as the Japan belladonna. The first chemical analysis, made by Langgard long ago, resulted in the isolation of an alkaloid, rotoine, from *roto,* the Japanese name of the plant, which exhibited all the properties of the alkaloids of belladonna. Scopolamine, indeed, exerts a mydriatic and a vaso-dilatory action (*i. e.,* it dilates the pupils and blood vessels), but it also expresses a narcotic power, which inevitably produces a profound and dreamless sleep.

There are four alkaloids of identical chemical composition, namely, atropine, hyoscine, cocaine, and scopolamine, their empirical formula being $C_{17}H_{21}NO_4$. In other directions, however, these alkalodis are very different substances. Still, the physiological action of hyoscine and scopolamine are so nearly identical as to lead to their substitution, the one for the other. In fact, excellent authorities state that scopolamine hydrobromide is identical with hyoscine hydrobromide, but lower in price. The question arises, then: Why, if they be identical, is the price under the one name less than it is when the same substance is sold under the other name? And this I will aim to explain, as follows:

The alkaloid discovered in scopolia, and named scopolamine, is probably a mixture of the alkaloid known as hyoscine and the alkaloid known as atroscine, which alkaloids are obtained from scopolia in greater abundance than hyoscine is obtained from hyos-

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cyamus. In other words, the alkaloid hyoscine, obtained in small amount from hyoscyamus in a very nearly chemical condition, is obtained from scopolia in larger amounts. Hence, when it is made from the drug scopolia, it can be sold cheaper than when it is made from hyoscyamus.

The physiological action of the material sold under the name scopolamine and the material sold under the name hyoscine are so nearly identical as to make them practically replaceable (in some directions, at least), the one for the other. In fact, the standard authorities at the present time consider them to be identical, and under the word *scopolamine* the latest authorities refer the reader for its action to *hyoscine.*

When this alkaloid unites with hydrobromic acid, it forms what may be called either hydrobromate of hyoscine or hydrobromate of scopolamine; but as the bulk of it is made from *scopolia* instead of from hyoscyamus, the term *scopolamine* is naturally being preferred by manufacturers. This term, however, is not as well known to physicians as the word *hyoscine.* Hence, physicians who find these terms used in replaceable positions may not comprehend just why the substance is thus separately designated.

To sum up, *hyoscine* and *scopolamine* are chemically identical, the one having been discovered in hyoscyamus, the other having been discovered in scopolia. The hydrobromate (or hydrobromide) of scopolamine has the same ultimate composition of the hydrobromate (or hydrobromide) of hyoscine, and thus permits of the same name. But since atropine and cocaine are also of the same chemical composition, it will be seen that this is not an evidence of identity in therapy. In our opinion, one has no more the right to dispense scopolamine for hyoscine than to label hyoscyamus as belladonna.

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Selected Articles

The Control of Syphilis and Venereal Diseases

BY PRINCE A. MORROW, M. D., NEW YORK.

I wish to express my sense of appreciation of the honor of being invited to appear before you this evening. I have accepted the invitation all the more willingly as it affords the oportunity of presenting before this representative body of medical men of Boston the general features of a plan of control which was inaugurated in New York, some eighteen months ago, by the American Society of Sanitary and Moral Prophylaxis, and I do this with the confident hope that a society similar in aims and purposes may be organized in this city.

It has long been recognized that the control of a class of diseases, which, in their genesis and mode of spread, are preeminently, social diseases, in the most difficult of all the problems of hygiene. These diseases are not only a grave danger to the public health, but, through their morbid irradiations, constitute a serious menace to the health and productive energy of the family, and thus become a powerful factor in the degeneration and depopulation of the race.

It is hardly necessary to spread before this body of medical men the pathological balance sheet of venereal infection in order to emphasize the importance of the subject for discussion this evening. Lest we forget the enormous debt created by these infections, and which humanity must pay in suffering, disease and death, let us glance for a moment at some of the more salient items in this exhibit. The mere inventory of the morbid conditions, chargeable to syphilis alone, would include entries from every department of pathology. A large number of morbid conditions formerly credited to other pathogenetic factors are now recognized as the product of syphilis.

Syphilis is met with, in some of its forms or manifestations at

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least, in every branch of practice. It furnishes a large contingent of morbidity in the practice of the neurologist, the gynecologist, the eye, ear, throat, and nose specialists, as well as the internist in general medicine. The significance of syphilis as a danger to health and life is not measured by its immediate effects. Acquired syphilis rarely overcomes the citadel of life by direct assault; its role is that of the sapper and miner. It undermines the constitution, weakening its organic defenses and inaugurating changes which render it an easy prey to other forces of disease. It is especially in its late or terminal stages that its worst effects are manifest, in lesions which seriously compromise the integrity of organs essential to life.

In the sphere of the nervous system alone we may place to the debit side of syphilis 90 per cent. of locomotor ataxia, more than 75 per cent. of ocular paralyses, a large but indeterminate proportion of general paralysis, paraplegia and hemiplegia; 80 per cent. of all cases of paresis give a syphilitic history,—all affections of a serious nature and, for the most part, incurable.

The pathologic liabilities of gonococcus infections are scarcely less formidable. Less than a generation ago it was not suspected by the medical profession that in what was regarded as a trivial local disease of the urethra there lurked a germ possessed of such pathogenetic possibilities as we now ascribe to the coccus of Neisser,—a germ which is susceptible of being taken up into the circulation, causing serious articular and often fatal systemic complications; an infection, which, in respect to the character and sum total of its dangers constitute a greater social plague, perhaps, than syphilis.

We are indebted to gynecologists for statistical evidence that it causes 80 per cent, of all deaths from inflammatory diseases peculiar to women, practically all the pus tubes, more than 75 per cent. of the suppurative pelvic inflammations and 50 per cent. of all gynecological operations performed by surgeons, to say nothing of the large number of women who are permanently invalided.

This pathological exhibit embraces only the direct damage to the health of the individual,— the personal risks of the disease.

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There is, however, another aspect of venereal morbidity and mortality which constitutes its peculiar social danger and gives to the work of prevention a distinctly humanitarian value. I refer to infections of the innocent and helpless members of society, from their introduction into married life. Unfortunately, marriage does not represent that asylum "pure and chaste" in which these infections find no port of entry.

Of syphilis it may be said that it is a most pernicious foe to the family; it is antagonistic to all that the family stand for. The function of the family is to create life, the effect of syphilis is to damage or destroy life. The function of the family is to produce children, healthy, well-formed and vigorous; the effect of syphilis is to so vitiate the process of nutrition that it results in beings blighted in their development and stamped with physical and mental inferiority.

Syphilis stand as the perfected type of an hereditary disease, the only disease which is transmitted in full virulence to the offspring. The bill of syphilitic heredity and mortality is appalling; it causes 42 per cent. of all abortion; 60 per cent. to 80 per cent. of all syphilitic children die in utero or shortly after birth; those that finally survive are the subjects of degeneration and organic defects which are susceptible of transmission to the third generation. Many look upon this as nature's scheme for the elimination of the unfit, but these children might have been born in conditions of physical soundness but for the syphilis of the parents.

The influence of gonorrhea as a depopulating factor is even more marked. A large proportion of gonorrheally infected women abort, while 50 per cent. are rendered permanently sterile.

The social danger of gonococcus infection is not limited to its influence upon pregnancy and conception; it is still further manifest in the infected risks conveyed to the offspring. A proportion variously estimated from 10 per cent. to 30 per cent. of all blindness is caused by gonorrhea, to say nothing of the vulvovaginitis, the arthritis and other accidental infections of children in family life. Such are some of the undeniable and scientifically demonstrated dangers of venereal diseases which render their prophylaxis the most important problem in preventive medicine that confronts us at the present day.

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When there is question of the control of any infectious disease dangerous to the public health we naturally turn to those who are officially charged with this duty. But we perceive that there is on the part of these officials absolute inaction. It would seem an anachronism in the present era of preventive medicine that a class of infections which entail such a vast amount of morbidity should be wholly ignored by our sanitary authorities. What is the explanation?

I have elsewhere stated my conviction that the prevention of these diseases is not a purely sanitary problem, it cannot be worked out from the sanitary side alone; moral issues enter as an essential factor and cannot be ignored. When we examine more closely into the nature of these diseases we must recognize that while they are diseases of the human body, due to microbic invasion, they are in a special sense diseases of the social organism. Their spread is determined by social conditions which lie entirely without the sphere of sanitary control. Their communicative mode, intrenched in the stronghold of privacy, cannot be reached. They are not susceptible to the application of strictly sanitary measures.

Obligatory notification, the essential condition of sanitary intervention, is not practicable, it is opposed by both social sentiment and professional ethics; here the medical secret dominates the situation. The responsibility for this official inaction is thus shifted to the shoulders of the general medical profession and the public.

Now the public cannot be expected to seek deliverance from danger which it does not appreciate and the significance of which it does not comprehend. The public has no adequate conception of the danger of these diseases and especially of their social dangers; the invalidism they produce, the sterility, the abortions, the blindness they cause, the vast mass of disease and misery they engender. The medical profession knows these facts and this knowledge carries with it a responsibility, a responsibility of which the medical profession cannot divest itself until it shares this knowledge with the public. The laity is clearly entitled to a knowledge which so vitally concerns its interest.

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Clearly, the first step in any real progress toward prophylaxis must be the education of the public and the creation of a social sentiment in favor of this preventive work. The fact that the public is averse to this enlightenment only emphasizes the necessity of a crusade against ignorance. It will be granted that public opinion has often a force much beyond its merits. There is no greater force for evil than ignorant public opinion, and a public opinion based upon tradition and prejudice is always ignorant. Witness the insensate fear of leprosy, and the barbarous inhumanity betrayed in the treatment of leapers in this country, notably in the case of the Syrian leper who was done to death by cruelty in West Virginia, so recently. Science tells us that a syphilitic or consumptive is ten times more dangerous as a source of contagion to others.

On the other hand, there is no greater force for good than enlightened public opinion. Witness the prompt and invaluable co-operation rendered by the laity in the crusade against tuberculosis.

Experience in dealing with other communicable diseases has shown that any infectious disease which is spread in the relations of family and social life cannot be brought under control without the co-operation of the public, and the first and most essential condition of this co-operation is the enlightenment of the public as to its dangers to the individual and society; further, the public cannot give an intelligent co-operation without a knowledge of the conditions under which the disease is spread and the modes of its contagion, direct and indirect.

Another fact, developed by experience, and which finds its special application here, is, the more the spread of a disease is independent of environmental conditions, the more it comes within the control of the individual, the more essential this enlightenment. Venereal diseases are distinguished from all other infectious diseases by the fact that they are voluntary infections; they are contracted and conveyed to others by relations voluntarily entered into. But they are none the less *ignorant infections* and, in the opinion of the public, *benign infections*. The man who contracts venereal disease is either ignorant of the risks of exposure,

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or believes it to be a benign affair. The man who carries this infection into his family does it ignorantly and without full knowledge of its dangerous consequences.

The education comprehended in our program is, however, much more comprehensive than thus far indicated. This general enlightenment of the public as to the extent and dangers of these diseases is simply a preliminary, designed to create a public sentiment in favor of an education which shall be more radical in its nature and more efficient in prophylactic value. Many thoughtful men are beginning to recognize that the education of the rising generation in a knowledge of the laws of life and sex is most important, but they must also recognize that this is not possible without the consent and co-operation of the public. Our educational program proposes an innovation upon the established system of home and scholastic education, which shall take account of the sexual organization of the individual, the origin and facts of life and sex which are now regarded as forbidden subjects.

Time and space will not permit me to enter into the full details of the scope of this education, the age at which it should be given and the agencies through which it should be imparted. The function of the medical profession is to insist upon the value of this education and supply the requisite knowledge, intrusting its practical application to those who command the facilities and are better qualified by experience and a knowledge of specific methods. This education should be begun early, before sensuality is awakened and the curiosity of youth in regard to the mysteries of life and sex takes on a dangerous turn. Upon this foundation should be built, later, instruction in the physiology and hygiene of sex which should include the true purpose of the sex function, its essential dignity, and further that its impulses should be educated, controlled and directed in a proper channel. Later, he should be taught the dangers, both physical and moral, which come from the irregular exercise of the sex function. The high purpose of this education is to teach young men how to live according to the laws of a healthy nature by letting them know what those laws are. It aims to promote clean living by cultivating a right attitude of mind toward the passions and

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appetites; its essential object is to promote continence as the surest prophylactic against venereal infection.

This innovation proposes to substitute sound, sanative and wholesome knowledge of the sex function for the erroneous and demoralizing instruction the youth now receives from ignorant and often vicious sources.

The fruit of this evil seed sown in the fertile mind of youth is, and always must be, evil. Men do not gather grapes from thorns, nor figs from thistles. Medical men who have the opportunity of observing the practical results of a system of education which is organized on a basis of secrecy and silence in all matters pertaining to sex cannot too strongly deprecate the blindness of educators whose spirit and practice is to ignore this most important fact of life.

One of the noxious growths of this harvest of evil is the idea almost universally prevalent that sexual intercourse is a necessity to the health of men, and which is so deeply grounded that it becomes a sort of "obsessional belief." This idea, coupled with its natural outgrowth, that a man has a natural right to gratify himself in this way, constitutes, in my opinion, the most powerful determining cause of masculine immorality. The lax social sentiment which accepts and tacitly sanctions the "sowing of wild oats" as a natural incident in the evolution of the adolescent is a contributory cause.

I shall not attempt to say in what degree the medical profession is responsible for this false physiologic doctrine. It is the duty of medical men not only to repudiate, but uproot, if possible, the physiologic procedure by teaching what is amply verified by experience, that continence in young men is not prejudicial to health, but is compatible with the highest physical and mental vigor.

The so-called "sexual necessity" has been invoked as a physiologic basis of the conventional code of morals, expressed in the double standard of morality for men and women. As before intimated, moral questions enter as an important factor in the venereal problem, and cannot be ignored in any intelligent attempt toward its successful solution. In considering this question

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it is important to recognize the distinction between the social code of morals and the moral code taught by Christianity. The late Senator Hoar, of Massachusetts, in one of his last published papers, thus defines conventional morality: "We mean by morals the rules of conduct which govern men in the ordinary social relations, which do not, in general, depend for their sanction on religion on the one hand, or the law of the State on the other." "In speaking of actions as immoral, we speak in general of those condemned by public opinion. The standard of private morals must be measured by the opinion of society," etc.

Now, the morality of many men,—I may say, of the average man,—is expressed in the formula that it is his private right to indulge his sexual appetite whenever and wherever he may find a receptive partner. This morality is accepted and tolerated by society, not theoretically, perhaps, but practically it is so tolerated, since no social stigma attaches to its practice.

While allowing himself the largest sexual liberty, man's standard of morality for women is quite different; he demands of woman an entire abstention from sexual intercourse before marriage and absolute fidelity after marriage. Women weakly accept man's standard, and while not demanding or even expecting premarital virtue in men vainly imagine that the mere fact of marriage will transform the polygamous man into a monogamous partner. A change in relation does not, however, alter character. Doubtless, a certain large proportion of men are restrained by a sense of sexual honor and infidelity, but, unfortunately, a man seldom lives a life of impurity without consequences, and these consequences, introduced into marriage, make up the saddest chapter in the martyrdom of women. The thousands of virtuous wives who suffer in ignorance disease, sterility and mutilation of their bodies, and in whom the holy office of maternity is desecrated by the production of abortions, tainted and diseased children, should know that the standard of morality they now tolerate in the men they marry is the responsible cause. This knowledge should come through general enlightenment of the public.

It will be admitted that a marked improvement in public morals has taken place through publicity. Certain public, political and

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commercial evils are no longer tolerated; the standard of business probity has been elevated. But while social sentiment ostracizes the drunkard, it still gives a free charter to the libertine. This ethical awakening has not penetrated the realm of private morals; man's morality is still the traditional morality, a survival of the domination of the strong over the weak, and based upon the theory of property ownership in women.

There can be no question that this traditional standard of private morals is an important etiological factor in the spread of venereal infection. It is believed that the education of the public along the lines already indicated—the exposure of the magnitude of the venereal peril, its significance as a social danger, the havoc wrought in the home and family—will do much in creating a public sentiment which will no longer tolerate these evils nor sanction the standard of morals of which they are the outgrowth. There is no need to educate, not only the intellect but the conscience of the people, which shall recognize a moral responsibility in sex relations and which shall develop a higher sense of sexual honor among men to the women they marry, and of fidelity to the interests of the unborn.

The medical profession has a grave responsibility in this regenerative and uplifting work. In so far as the existing standard of private morals rests upon a false physiologic foundation, it should be swept away.

It may be said that it is not the province of the physician to teach morals; many physicians claim that we should eliminate all questions of morality and study this problem solely from the standpoint of the sanitarian. I make no apology for the intrusion of this educative work in the domain of morals. The successful solution of the problem of prevention can never be approached from the sanitary side alone. Social morals and social diseases are indissolubly linked on the relation of cause and effect. Here, at least, public health and public morals are one and indivisible. Whatever makes for morality is a distinct gain in the diminution of venereal infection; reciprocally, all hygienic teaching which conduces to clean living makes not only for the physical but the moral health of the individual and society.

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TREATMENT.

The prophylactic value of this purely sanitary measure is so generally recognized that it is scarcely necessary to insist upon it. While the primary and specific object of treatment is to cure the patient, the prompt sterilization of sources of contagion prevents infection of others; moreover, the treatment of the patient affords the opportunity of instructing him in regard to the danger of the disease to himself and others, the laws of its contagion, especially the duration of its contagious activity and its modes of communication. The physician but half fulfills his duty by merely prescribing for the patient while omitting this instruction.

It will be admitted that the existing provisions for the treatment of this class of cases are insufficient and badly organized for the purpose. Venereal patients are discriminated against or barred from admission to general hospitals while no special hospitals are provided for their reception.

In an investigaton made by myself, not long ago, into the organization of our present hospital system with especial reference to this class of cases, letters were addressed to leading genito-urinary specialists in all the large cities in this country. The replies showed that there was but one single special hospital in the United States for these diseases, and that this was not used exclusively for this purpose. New York City provides only twenty-six beds for female and something over twice that number for its male patients, suffering from these diseases in an acute form. I may refer to one or two gross abuses growing out of these insufficient hospital accommodations, coming under my personal observation in the City Hospital. Respectable married women infected by their husbands are compelled to inhabit the same ward and sleep in beds side by side with the most abandoned prostitutes. A young girl who may have taken only the first step in the downward path and has been robbed of her virtue and her health at the same time is not likely to be reclaimed after being exposed to the demoralizing influences of these adepts in vice; young girls, under fifteen years of age, when found diseased, usually from criminal assault, who come under the care of the

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Society for the Prevention of Cruelty to Children, are placed in this same ward and detained until cured.

Fortunately, the vast majority of this class of patients are ambulatory and require only dispensary treatment. The dispensary services, are, as a rule, not organized with reference to the peculiar shameful nature of venereal diseases in popular estimation. The conditions are such as to repel rather than attract this class of patients, as the nature of their disease is apt to be suspected or positively known by the other occupants of the waiting room. Under these conditions it is not surprising that so many venereal patients seek the seclusion of the out-of-the-way office of the advertising quack or prefer the secrecy assured by a sealed package of medicine whose inviolability is assured by the United States Postal Department.

The prophylactic value of treatment may be vastly improved by a reform of these and other abuses. What is required are enlarged facilities for treatment which shall be gratuitous, which shall be convenient and available and which shall be adopted to the private nature of the disease.

Social prophylaxis embraces measures of a general order which relate to social causes and conditions that favor the spread of venereal infection. It is evident that no comprehensive scheme of prophylaxis can be framed which ignores the chief source of these diseases and the agency by which they are commonly propagated, viz., the social institution known as prostitution.

Since moral, as well as sanitary, measures enter as component parts of this scheme of prophylaxis it does not include the system of *reglementation* employed in continental countries. Apart from objections on moral grounds and the hostility of public sentiment in this country to its adoption, it is condemned by its practical results, it does not materially diminish the sum total of venereal morbidity in countries where it has been most perfected and longest employed.

So far as relates to prostitution as a social institution it is proposed to take up the study of the underlying causes, material and economic conditions, etc., and present the results of this study for the education of public opinion. The essential object in

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view in dealing with the social evil is to prevent the *making* of prostitutes by correcting, as far as possible, the conditions which lead to prostitution. The making of prostitutes may be prevented in a measure by protecting young women against seduction, not only by education, but by safe-guarding minors in every possible way. By combating proxenetism in all its forms and severely punishing the purveyors of prostitution in whatever guise they are found, whether the cadet, the white slave trader or the employment agent.

The industrial and occupational dangers of young girls of the working classes and other conditions of living which lead to prostitution come within the scope of this prophylactic work.

It is evident that the problem of prevention is most complex in its causes, and that sanitary measures must be supplemented and reinforced by influences and agencies which can more effectively intervene in the correction of the conditions under which these diseases are spread, and for this purpose it is necessary to enlist the co-operation of all the social forces which work for good in the community. Hence the necessity of a society, composite in character, which shall embrace in its membership medical men, representatives of the clergy, of the law, educators, sociologists and public-spirited citizens interested in the social welfare.

In closing this paper which has extended beyond the proposed length, I may refer to the work done by the society organized in New York last year, and indicate briefly what has been learned and what has been accomplished by eighteen months of experimental work directed thus far chiefly along educational lines.

In the first place, we have learned that the work is most difficult, and that it is necessary "to labor and to wait" for results. The late William H. Baldwin, chairman of the Committee of Fifteen, who was consulted in the organization of this movement and who was profoundly impressed with its importance and deeply solicitous of its success, advised us "to go slow." This advice was entirely unnecessary, and, in the light of present experience, appears almost ironical. "To go slow" is the only mode of locomotion.

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We have found:

On the part of the mass of the medical profession a general recognition of the importance of this work, a practical unanimity of sentiment as to the necessity of doing something towards checking this evil, but a more or less pronounced incredulity as to its accomplishment. A certain large and influential element, I may almost say, the best element, in the medical profession of New York City, has given its moral support by becoming members, a still more restricted number are giving their active co-operation. A few are openly hostile, deprecating any attempt to make public evils which they claim ought, in the interests of decency and social propriety, to be concealed.

On the part of the general public an indifference, evidently the consequence of ignorance, and this on the part of many persons of superior intelligence in other matters—public-spirited citizens, prominent in social work, and whose co-operation would be invaluable—a reluctance to identify themselves with this movement, an aversion to personal engagement in this work because of its unsavory character. At the same time, a large number of the very best men in every department of social life have given in their adhesion, doubtless impelled by a sense of duty; one distinguished divine declares that his conscience compelled him to join in this movement.

On the part of educators, and, especially, directors of physical training in schools, colleges, associations and settlements,—men who have the opportunity of observing the evil results of our faulty system of education,—the keenest appreciation of the educative feature of our program.

Finally, on the part of the public press, a veritable Chinese wall of traditional prejudice, which closes any advance to publicity in this direction. Editors of newspapers are most loyal champions of the "conspiracy of silence." One notable exception, the *Charities and Commons,* has given us most effective support.

What has been accomplished? It is, perhaps, premature to expect definite results. The mere agitation of this subject has been of immense service in awakening the perceptions of both the

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medical profession and the people to the magnitude of a social danger which social sentiment and professional ethics have always united to cover up and conceal.

Societies with similar aims and purposes have been organized in various cities, Detroit, Chicago, Milwaukee, Philadelphia. The society in Philadelphia has over seven hundred medical men in its membership. Many district medical societies are now taking up this work.

The policy of frank and open discussion of these forbidden topics inaugurated by our society has given courage to many of the laity to break with traditional restrictions and to speak out their innermost convictions.

The molding of public opinion to the importance of this work is as yet only in the formative stage, but the receptivity of the public mind to the knowledge we wish to convey is a most cheering indication. This society is receiving from serious-minded men and women all over the country requests for literature which shall throw more light on the situation. The indications are unmistakable that a sentiment in favor of this work is deep, widespread and constantly growing.

There have been numerous demands from societies, schools, settlements and various social groups for lecturers who shall give talks to young men. The extension of the educative work of the society in this direction has been made possible by the generous contribution of two of our members toward the establishment of a lecture fund, which will not only enable us to supply existing demands, but still further expand the work of this society, by organizing a regular system of lectures, in various parts of the city. It is proposed to employ as lecturers only those who are specially fitted for this delicate and important work.

I fear that I may have overtaxed your patience in this exposition of a system of prophylaxis which is planned along the lines recommended by the last Brussels Congress, and has been adopted by the American Society with material modifications and additions, and which may be still further modified, and, it is hoped, improved, with the larger wisdom gained by practical experience. No one knows better than myself that it does not

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realize the ideals of a perfect system. It presents the advantages, however, of being practical, available and promises to be effective in limiting at least the evils we wish to prevent. In dealing with this important problem of social hygiene, the solution of which has always been the despair of sanitary science, it subsittutes interest for apathy, action for inaction, the energy of hope for the impotence of despair.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

Varicose Veins of the Lower Extremities and Their Treatment.

P. T. O'Connor considers the causes of varicose veins as predisposing and exciting. The valves of the veins play an important part in the etiology of varix. Occupation also plays an imporant part in the production of varicose veins. Those whose work keeps them habitually on their feet are apt to suffer. There seems to be an hereditary influence also which predisposes to this condition. The writer believes that it is not alone the greater degree of surgical skill and dexterity that determines success in the management of these cases, but a factor of equal importance appears to be the aseptic precautions necessary to be carried out before, during, and after manipulation.—*Medical Record.*

The Diagnosis and Surgical Treatment of Gastric and Duodenal Ulcer and Their Complications.

A. A. Berg points out the difficulty of making diagnosis in certain cases of gastric and duodenal ulcer. With reference to the diagnosis of the complications of gastric and duodenal ulcers, one need rarely be doubtful if there is a previous history of such a condition. From his experience the writer believes that operation is not advisable when the patient's general condition is bad, the hemoglobin very low, 19-20 per cent., and the pulse not very rapid. In such a conditon, even a slight operative shock, whether or not it is combined with the influence of a general anesthetic, is sufficient to cause the death of the patient. In such cases internal remedies and complete rest, induced by morphine, to check the bleeding, are far preferable. When the patient's general condition is still good, however, immediate operation is strongly indicated.—*Medical Record.*

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SURGICAL KIDNEY.

G. F. Lydston, Chicago (*Journal A. M. A.*, December 8), publishes a number of clinical histories of cases of surgical diseases of the kidneys that are of interest. In connection with cases reported of malignant diseases, he remarks that while blood in the urine, in conjunction with a solid tumor of the abdomen located behind the colon, is generally regarded as pathognomonic of renal cancer, exceptions occur in which hemorrhage is wanting, as Roberts has shown. Hematuria also is not constant in the beginning of renal cancer, as two of Lydston's cases here reported, demonstrate. As a rule, however, it occurs in considerable quantity. A case of kidney abscess illustrates the recuperative power of the kidney, which, after the operation, only a mere remnant, resumed its functions. Although it is difficult to lay down rules, Lydston is inclined to deem it safer to perform only nephrotomy unless there are special indications for nephrectomy in a given case. Another case of sarcoma followed an exploratory operation for suspected calculus, which revealed no evidence of neoplasm. This and a similar case in the author's experience are suggestive of a premalignant stage of such growths, and raise the question as to whether a nephrectomy would not sometimes be justifiable in cases in which all the symptoms of calculus are present, but none is revealed by exploratory operation. The possibility of a circulatory disturbance existing and being responsible for the symptoms must of course be considered. Other cases reported are of tuberculosis and of calculus. The article is illustrated.—*The Journal.*

NEW METHOD OF STERILIZING CATGUT.

Dr. P. C. H. Pahl, of Los Angeles, Cal., translated for the *Practitioner* from *Centralblatt fur Chirurgie,* the method discovered by Professor Dr. Oscar Bloch, for sterilizing catgut.

The ordinary catgut of commerce is wound on glass spools, care being taken not to wind too much nor too tightly, so as to prevent the underlying strands from coming in contact with the solutions. Without any preliminary preparation the wound spools

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are placed in an aqueous solution of iodine and iolide of patash (iodine one part, potassium iodide one part, and distilled water 100 parts; dissolve the K. I. in a small quantity of water, then add the finely powdered iodine. When dissolved, add the rest of the water).

The solution is placed in a glass-stoppered jar of suitable size, which is labelled and dated, and at the end of eight days the catgut is ready for use and is allowed to remain in the same solution and container for indefinite preservation. When it is to be used, the spool is removed, it is rinsed in a three per cent. carbolic acid or any other sterile liquid, whereby the surplus solution is washed off. The ligatures are cut off in the carbolic acid solution, and that which is unused is placed back in the jar.

This method of preparing catgut makes the gut very dark and it assumes a peculiar consistency which is at the same time pliable and elastic, not unlike a thin copper wire, and is very readily tied.

This method of sterilization is absolutely safe, as shown by Dr. Claudius through extensive laboratory experiments. The ligature is not only sterile, but, through the iodine which it contains, actively antiseptic, so that handling it with the hands is not liable to infect it. It is absorbed in from twelve to fifteen days, perhaps somewhat slower than the carbolic-and-alcohol-prepared gut. Local irritation is not produced by the poisonous action of the iodine, for the reason that the pure iodine in the tissue soon forms non-irritating substances.—*Med. Bulletin.*

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MEDICAL

The House Fly and Its Connection with Disease Dissemination.

G. K. Dickinson states that of the seven different varieties of flies found in our houses, 98 per cent. is the common house fly (*Musca domestica*). They are born in manure or in decomposing matter of any kind. Their tasts are indelicate and omnivorous, and they subsist on sputum, fecal juices, and the slime and dirt that stick to exposed surfaces. The writer reports the results of experiments by various investigators. He declares that the importance of flies as a factor in the dissemination of diseases depends largely upon other existing conditions. The possibility of a spread of any type of infectious disease by this insect has been conclusively proved. From experiments the relative danger is as follows: The dejecta, the proboscis, the crushed or ingested insect and the outside parts. The writer declares that scientifically speaking the number of flies in a community is in direct proportion to the carelessness of its sanitation. The greatest care should be taken to destroy as many of these insects as possible and to protect houses and their contents from those that remain.—*Medical Record.*

A Few Remarks on Medical Expert Testimony.

George Franklin Shiels considers this subject under various headings. He believes that expert medical evidence could be of the greatest value in upholding justice if it were properly introduced. He suggests two plans. (1) Let the attorneys of each side select two experts and let the four thus chosen choose a fifth. These five men could, after mature deliberation, present a full and useful report on any technical points considered by them. Or, (2), the matter could be left in the hands of the court, who could tell one or a dozen medical men to elucidate without prejudice any technical points that might arise in the trial. The writer favors the plan in which the court has control.—*Medical Record.*

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A PLEA FOR A MORE RATIONAL THERAPY IN TUBERCULOSIS.

F. M. Pottenger says that the original tuberculin of Koch, his later preparations, as well as numerous preparations made by other men, if used properly, will stimulate the cells of the individual suffering from tuberculosis to the formation of defensive bodies, as is shown by the increase of the agglutinating and opsonic power of the blood. There are also certain sera which seem to furnish the antibodies already formed, which are of some value. The best known of these are the Fisch, Maragliano, and Marmorek sera. One of the chief aims of the physician should be to maintain nutrition at the highest point. The hygienic-dietetic-open-air treatment has for its basis the betterment of nutrition. Open air is not a cure for tuberculosis. Used properly, however, it is one of the greatest aids to nutrition that can be employed. Open air should be supplemented by proper food and carefully regulated rest and exercise to make it most effective. Hydrotherapy is another measure of great value. The cheering and toning effect of sunshine is a very potent factor in aiding nutrition. The giving of raw meat or muscle juice is also indicated. All distressing symptoms and complications should be carefully managed. In relation to this disease, the writer urges a broader view and a more rational therapy, which considers the condition in all its varied aspects.—*Medical Record.*

A CURED CASE OF LIVER ECHINOCOCCUS BY EMPLOYMENT OF BACCELLI'S PROCEDURE.

Klemen (*Archiv. f. Kinderheilk.*, vol. 41, 1906). The patient was a girl six years of age. The treatment consisted in the evacuation of 30 ccm. of fluid from the echinococcus sac, followed by the injection of 20 ccm. of a solution of mercuric bichloride (1:1000). The interference was repeated several times at intervals of one to three weeks, a new injection being administered as soon as the diminution of the liver swelling, which took place after the interference, began to show no further progress.—*Medical Review of Reviews.*

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OBSTETRICAL

The Hyoscine Sleep in Obstetric Practice.

Woodbridge Hall Birchmore believes that hyoscine is for the accoucheur the ideal anesthetic. He knows of no experience with an excessive dose. The importance of the hyoscine sleep in obstetric practice is amply demonstrated. It gives all the aid in quieting the patient that any narcotic can give, while in addition it affords a practical anesthesia of prolonged duration without risk to either mother or child. This anesthetic sleep is without danger. Hyoscine is a drug sedative to the cerebro-spinal axis, but not to the ganglia connected with the reflexes of common life.—*Medical Record.*

DILATATION OF THE CERVIX, ARTIFICIAL.

The writer describes the mechanism of normal cervical dilatation and its differences in primiparæ and multiparæ, its condition in early and late abortions and in premature and full-term delivery. The cervix acts as a sort of sphincter in opposition to the other uterine muscles, and the barrier it produces can be overcome in three ways: 1. by stimulating the uterine contractions by the introduction of foreign bodies, etc.; 2, by overcoming the sphincter action by manual or instrumental means; and 3, by incision. Previous to the introduction of the Bossi dilator the author incised cervices, but since then has done this in very few cases. His experience has taught him that after the thirtieth week mechanical methods will suffice in most cases, and bimanual stretching of the cervix has given the best results. It is a closer imitation of the natural process than any other. It allows greater force. There is less danger of rupture of the membranes or of laceration. It does not interfere with the original presentation. It is less fatiguing. In placenta of the membranes or of laceration. It does not interfere with the original presentation. It is less fatiguing. In placenta prævia there is less separation of the placenta, and last and

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most important, in the writer's opinion, it can be performed while a part of the fœtus already occupies the vagina. When much resistance is encountered from the non-disappearance of the supravaginal portion of the cervix and time does not permit the use of hydrostatic bags, the author finds the Bossi dilator invaluable. Ten or fifteen minutes' use of this in such cases sets up uterine action, softens the cervical rings, and permits a subsequent safe manual dilatation. The author never uses it to complete the dilatation, as he considers it unsafe for that purpose. For slow cervical dilatation his main reliance is on the hydrostatic bag of the Champetier de Ribes type.—*J. Clifton Edgar (Journal of the American Medical Association*, November 10, 1906).

For Corneal Opacities.

Dr. A. Bourgeois (Union Med. du Nord. Est., No. 7, 1906; Journ. de med. et de chir. prat., September 25, 1906) points out that corneal opacities often contain salts of lime. Anything which will dissolve them should prove serviceable, then. He uses a collyrium composed of—

℞ Lithium benzoate.....0.50 (7½ grains);
Sterilized distilled water...10.00 (150 minims).

The dose of the lithium salt may be carried as high as a gramme (15 grains). Three or four drops are instilled between the eyelids morning and evening. Dr. Bourgeois states that lithium benzoate does not produce any irritation of the tissues, the cornea especially; but he utters the caution that the dose may be diminished if the patient displays pain with conjunctival hyperæmia.—*St. Lous Medical Review.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages, at $1.00 a year, to be always paid in advance.
All bills for advertisements to be paid quarterly, after the first insertion of the quarter.
Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.
All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

THE CONVICTION OF DR. J. HERMAN FEIST OF MURDER IN THE FIRST DEGREE.

A trial which has just resulted in the conviction of murder in the first degree of a well known and popular young physician of this city has for some weeks been closely watched by the public of this community, but more especially by the medical profession, inasmuch as it is the first time in the criminal annals of this city that a member of the profession has been arraigned before the bar of justice on the terrible charge of wilful and deliberate, cold-blooded murder. The verdict came in the nature of a profound surprise to almost every one who had watched the course of the sensational trial from its beginning to its end, especially as it was generally thought that the State had failed to prove the venue and to establish clearly the corpus delictu. The evidence was entirely circumstantial, but was unusually strong, and was ineffectually, it would seem, fought by the defense.

There now remains to the unfortunate prisoner the granting of a new trial, and in the event of failure in that direction, an appeal to the Supreme court.

The members of the medical profession in this city are deeply grieved that such a stain as this should through one of its body sully its honorable records, but believes with the rest of the public, that if guilty, the accused should expiate his crime on the

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scaffold. Without going into the details of the sensational case which has been voluminously reported in the secular press, we present a brief history of the crime as given in the daily *American*:

HISTORY OF THE CRIME.

"The reports of the celebrated trial have familiarized the public with the facts of the tragedy. Mrs. Mangrum had drawn all of her money out of the bank, collected together all of her personal effects and announced that she was going to Chicago on the night of December 14, 1905. The testimony of the State takes her to the Union Station, where she disappears, and six weeks later her body is found in the Ohio River, near Cairo, Ill. The defendant is identified by E. H. Mitchell, a liveryman, as a man who hired a horse with flaxen mane under the name of Dr. Bean. This horse and buggy is traced to the Union Station and starts North. Old man Stone thought he saw a woman get into the buggy at the Station. Several days before the recovery of the body witnesses believed they saw the body of a woman floating by Clees' Ferry in the Cumberland River.

Chief of Detectives Sidebottom and Detectives Irwin and Dowd pursued the investigation of every clue. The detectives first endeavored to establish the fact as to whether Mrs. Mangrum left Nashville on the night she was last seen. Many trainmen were interviewed, and without exception could recall no passenger of the description of Mrs. Mangrum. The detectives were convinced after weeks of work that Mrs. Mangrum did not leave Nashville on the night she was last seen alive, and went to work to collect evidence of her movements here.

When Gen. Washington stated in his argument that "luck was against the player of fortune who sat at the table of chance," he struck the keynote that seems to have marked the fate of Dr. Feist. For days the State placed before the jury the most damaging circumstantial evidence, and the verdict shows that the strong efforts to break it down were unsuccessful. The case of the defense was weak at many points."

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Tennessee State Medical Society.

The following letter explains itself. The attention of doctors throughout the State is called in this manner to the approaching meeting of the State Medical Society, and we hope the response will be liberal, and that all will unite in the endeavor to make the forthcoming meeting profitable and enjoyable:

Dear Doctor:—The regular annual meeting of the Tennessee State Medical Association, convenes in Nashville, April 9 to 11.

We are exceedingly anxious to have a full and attractive programme, and to that end extend you an invitation to be present and present a paper.

It is our aim to arrange the programme in such a manner as to bring papers on related subjects into groups, so that they can be read and discussed together, believing that in this way we can derive the greatest good, for the largest number, in the shortest possible time.

Remember that the time limit for the reading of a paper is twenty minutes, consequently it will be of great advantage to you as well as the other members present to come within this limit, and thus avoid the leaving out of important points you desire to make.

We have delayed sending out this notice and request until this time, for when sent early it is often laid aside and forgotten.

Your Committee on Scientific Work will attempt to arrange the subjects so as to get the very best results for the meeting, and to this end we ask the earnest co-operation of every member, and especially urge you to respond as soon as possible to this communication, so that we can issue a preliminary programme. Now is the time to act, and we hope to have a prompt response.

Yours very truly,

Geo. H. Price, *Secretary.*

Pennsylvania Raises the Requirements for Admission to Medical Schools.

Recognizing the advantages of a broader general education

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and the growing necessity of the prospective student having in addition special preparation for the study of medicine, the Board of Trustees of the University of Pennsylvania has decided recently to raise the requirements for admission to its medical school. These requirements include two years of general college training and in addition a certain knowledge of biology, chemistry and physics. According to the plan which has been adopted, the standard will be raised gradually, beginning with the academic year 1908-1909 and reaching the maximum 1910-1911.

Louisville, Ky., January 18, 1907.

Dear Doctor:—At the last meeting of the Mississippi Valley Medical Association it was decided to offer a prize of $100 for the best essay on some medical or surgical subject.

The competition is to be limited to those who, at the time of entering the competition as well as at the time of the reward, shall be members in good standing of the Mississippi Valley Medical Association.

The award will be made by a committee appointed for the purpose, consisting of Drs. Hugh T. Patrick, of Chicago, A. H. Cordier, of Kansas City, and Chas. H. Hughes, of St. Louis. The name of the author is to be enclosed in a sealed envelope bearing some motto or device and the essay is to be marked by the same motto or device. The name of the successful author and the title of his essay will be announced at the next meeting of the Association, to be held in Columbus, Ohio, October 8, 9, 10, 1907, and the award will be made at that time. The successful essayist will be notified at least two weeks prior to the meeting, and he will be expected to read his essay at that meeting. The essay is to be published in the organ of the Association.

All essays must be typewritten, and are to be sent to the Secretary, Dr. Henry Enos Tuley, 111 W. Kentucky Street, Louisville, Ky., on or before August 1, 1907, after which date no essay will be received.

The committee reserves the right to reject any or all essays.

HENRY ENOS TULEY.

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Reviews and Book Notices

Whitman's Orthopedic Surgery. A Treatise on Orthopedic Surgery. By Royal Whitman, M. D., Instructor in Orthopedic Surgery in the College of Physicians and Surgeons, New York; Chief of Orthopedic Department in Vanderbilt Clinic, New York. Third edition, revised and enlarged. Octavo, 900 pages, with 554 illustrations, mostly original. Cloth, $5.50, net. Lea Brothers & Co., Philadelphia and New York, 1907.

The third edition of this popular text-book thoroughly revised and brought fully up to date has been received, and we take pleasure in stating the high opinion thorough perusal of the work has caused us to entertain of its value. The author has taken great pains to make it a book that will prove of benefit to the general practitioner as well as the specialist, and we think he has succeeded admirably in carrying out his object. We are particularly struck with his directions for examination and of measures advocated, not only for the correction of deformities, but also for the prevention of threatened deformities. We take pleasure in commending the work as a guide for students and practitioners that possesses many features of usefulness.

Peterson's Obstetrics. The Practice of Obstetrics. By Eminent Authorities. Edited by Reuben Peterson, A. B., M. D., Professor of Obstetrics and Diseases of Women in the University of Michigan, Department of Medicine and Surgery, Ann Arbor, Mich. Large octavo, about 1087 pages, with 523 engravings and 30 full-page plates in colors and monochrome. Cloth, $6, net; leather, $7, net; half-morocco, $8, net. Lea Brothers & Co., Philadelphia and New York, 1907.

This new claimant for professional favor will, we feel sure, meet with the heartiest reception from all physicians interested in this important branch of medicine. It is the concluding volume of the Practitioner's Library of Gynecology, Obstetrics and Pediatrics, the two preceding volumes having been received with every mark of appreciation by the profession. It is a work made

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up of the contributions of men who are accepted as authorities on the various subjects assigned them, and it is a trustworthy exposition of the subject in all its pathological intricacies and therapeutic difficulties. We have been especially attracted by the richness of the illustrations, which are numerous and original for the most part. The entire library of three volumes should be in the hands of every practitioner, as it constitutes a complete presentation of the three closely correlated specialties. We are vastly pleased with the work and unhesitatingly commend the work as the most complete modern work upon the subject, and as an exhaustive and scientific exposition of the subject handled by authors whose experience renders their writing authoritative.

Syllabus of Lectures on Human Embryology. An introduction to the study of Obstetrics and Gynæcology for Medical Students and Practitioners; with a Glossary of Embryological Terms. By Walter Porter Manton, M. D., Professor of Clinical Gynæcology and Professor Adjunct of Obstetrics in the Detroit College of Medicine; Fellow of the Zoological Society of London, of the Michigan Academy of Sciences, etc., etc. Third edition. Revised and enlarged. Illustrated with a colored frontispiece and numerous outline drawings. 12mo, 136 pages; interleaved throughout for adding notes. Bound in extra cloth. Price, $1.25, net. F. A. Davis Co., 1914-16 Cherry Street, Philadelphia, Pa.

The third edition is before us thoroughly revised and brought fully abreast with the most recent advances in this department of medicine. It is an outline of the study of embryology and as such it will be found of the greatest practical aid to students and practitioners in this very difficult study.

On the Nature, Causes, Variety and Treatment of Bodily Deformities, in a series of Lectures, delivered at the City Orthopædic Hospital in the year 1852, and subsequently by the late E. J. Chance, F. R. C. S., Eng., Surgeon to the City Orthopædic Hospital; Senior Surgeon to the Metropolitan Free Hospital; Formerly Lecturer on Practical Anatomy at the Aldersgate and Hunterian Schools of Medicine, etc. With illustrations drawn on wood. By the Author from Cases in His Own Practice. And many additional Drawings and copious Notes from cases

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in the editor's practice. Edited by John Poland, F. R. C. S., Eng., Surgeon to the Orthopædic Hospital; Senior Surgeon to The Miller Hospital; formerly Senior Demonstrator of Anatomy at Greg's Hospital, etc. Author of "Traumatic Separation of the Epiphysis," "Skiographic Atlas," "Retrospect of Surgery During the Past Century," "Records of The Miller Hospital," etc. Second edition. In two volumes. Vol. I. London. Published by Smith, Elder & Co., 15, Waterloo Place. 1905.

An exceedingly valuable work consisting of a series of lectures delivered as far back as 1852 by the distinguished orthopædic surgeon, and edited by John Poland. The work commends itself to the surgeon by its originality of conception, and the unusual way in which the important subjects have been handled.

Practical Dietics.—With Reference to Diet in Disease. By Alida Frances Potter, Graduate Department of Household Arts, State Normal School, Farmingham, Mass. Late Instructor in Dietetics, Bellevue Training School for Nurses, Bellevue Hospital, New York City. Former Instructor at Lakeside, St. Mary's, Trinity, and Wisconsin Training School for Nurses, Milwaukee, Wis.; St. Joseph's Hospital, Chicago, Ill.; Special Lecturer at Bellevue, Mount Sinai, Hahnemann, and the Flower Hospital Training Schools for Nurses, New York City; St. Vincent de Paul Hospital, Brockville, Ontario, Canada. Fourth edition. A. F. Potter, Publisher, Mount Vernon, New York, 52 W. 39th St., New York.

Four editions of this excellent book have been called for. The author has taken advantage of the demand for a new edition to make a careful revision, and a number of important changes. The value of the work is attested by its acceptance as a text-book in many places. It should be in the hands of every trained nurse, as we consider the preparation of food for the sick as no small part of the essentials of a thorough training.

Conservative Gynecology and Electro-Therapeutics.—A practical Treatise on the Diseases of Women, and Their Treatment by Electricity, by G. Betton Massey, M. D., Attending Surgeon to the American Oncologic Hospital, Philadelphia; Fellow and ex-President of The American Electro- Therapeutic Associa-

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tion; Member of The American Medical Association, etc. Fifth Revised Edition. Illustrated with twelve original full-page, Chromo-lithographic Plates and fifteen full-page Half-tone plates of Photographs taken from Nature, and Numerous Engravings in the Text. Philadelphia. F. A. Davis Company, Publishers. 1906.

This excellent work, appearing now in its fifth edition, is so well known as to need but the mention of its publication to insure its favorable reception. In this age of operative gynecology it is refreshing to see a work that above all things advocates conservatism. The author is widely known as a leader in the domain of electro-therapeutics as applied to diseases of women. It is a well constructed book and deserves the fullest commendation.

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Publisher's Department

Acute Nasal Catarrh.

The conditions obtaining in acute nasal catarrh are essentially those of an inflammation of any mucous membrane, first, an engorgement of the capillaries, then an exudation of serum into the tissues, then a further exudation on the part of the mucous or serous membranes.

To attempt to terminate the trouble or alleviate the discomfort by an astringent or any wash of an acid nature, is simply to temporarily lessen the secretion without in any degree reducing the congestion or stimulating the local circulation, thus actually rendering the condition worse than before.

A remedy to be effective must first empty the mucous membrane and then prevent a re-engorgement by stimulating the blood-vessels into increased action and compelling them to resume their normal functions.

This is pre-eminently the province of Glyco-Thymoline.

By its power of promoting exosmosis it purges the mucous membrane as soon as it is brought into contact with it.

By its anesthetic property it soothes the pain, and by its power of stimulating the circulation it relieves the capillaries of their local congestion and restores the normal circulation.

The immediate cause of a catarrhal discharge is an engorged mucous membrane. Empty by exosmosis and you relieve instantly.

In the general treatment of nose and throat troubles, especially when inflammatory conditions prevail and palliative treatment is called for as a preliminary to operate interferences, no other remedy gives the immediate relief and establishes the aseptic conditions afforded by Glyco-Thymoline.

"Salicylates act at least in two ways in the body. In the case of acute articular rheumatism, in which they are suposed to exercise a specific influence, they probably act deleteriously upon

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the micro-organism which is responsible for the malady, whereas, in the case of chronic rheumatism or gouty conditions, depending upon diathetic states they product some influence upon metabolism or the oxidation processes in the body which we do not understand, but of which we are therapeutically certain."

It is of the greatest importance, therefore, that the salicylic acid administered should be from natural sources, and not the synthetic product. Physicians can rely on the fact that all the salicylic acid in Tongaline is made from the pure natural oil of wintergreen and that it does not possess the disturbing effects of the salicylic acid made from coal-tar.

A Sterile Eye Bath.

An eye bath fashioned from a single piece of aluminum has been introduced by the Kress & Owen Company. That this little device will be well received by the medical profession is not to be questioned when one considers the many points of advantage this metal cup has over the old style glass contrivance. It is cleanly, unbreakable and can be sterilized instantly by dropping into boil-water. The surgical bag in the future will hardly be complete without one of these cups, which will give happy results in many an emergency. It will be found invaluable for treating Ophthalmia, Conjunctivitis, eye strain, ulceration and all inflammatory conditions affecting the eye.

Directions.—Drop into the eye bath ten to thirty drops of Glyco-Thymoline, fill with warm water; holding the head forward, place the filled eye bath over the eye, then open and close the eye frequently in the Glyco-Thymoline solution.

No pain or discomfort follows the use of Glyco-Thymoline. It is soothing, non irritating, and reduces inflammation rapidly.

I have had good results with the alkaloids. Yesterday I had opportunity to test your method of hypodermic anesthesia. A woman had the end of her finger torn from the second joint, badly

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lacerating the muscle above, which required my taking off a pieces of the bone. I injected one tablet and in due time, with but four or five drops of chloroform, she was asleep and the necessary operation was performed without the slightest pain.

M. H. WESTBROOK.

Olmsted Falls, Ohio.

—From the *American Journal of Clinical Medicine.*

CLINICAL REPORTS OF THE NEW HYOSCINE MORPHINE AND CACTIN ANESTHESIA.

I gave the hyoscine, morphine and cactin compound a trial today in a case of locomotar ataxia of three years' standing, in which three grains of morphine (hypodermically) had no effect. This patient had been using morphine for more than nine years; had not had any morphine for eighteen hours previous to the hypodermic injection of the hyoscine, morphine and cactin compound, and thirty minutes after injection there was complete surgical anesthesia. F. V. DOTTERWEICH.

Ashland, Ohio.

—From the *American Journal of Clinical Medicine.*

Since using the hyoscine-morphine and cactin tablets in a number of different cases, I would not be without them. They are valuable in obstetrical as well as surgical work, and in many other cases where morphine or hyoscine is needed. The hyoscine prolongs the rest so well in pain cases that a second dose of morphine is not needed nearly as often. J. W. ROBINSON.

McCammon, Idaho.

—From the *American Journal of Clinical Medicine.*

Chemical Food is a mixture of Phosphoric Acid and Phosphates, the value of which Physicians seem to have lost sight of to some extent, in the past few years. The Robinson-Pettet Co., to whose advertisement (on page ——) we refer our readers, have placed upon the market a much improved form of this compound, "Robinson't Phosphoric Elixir." Its superiority consists in its uniform composition and high degree of palatability.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. MARCH, 1907. No. 8

Original Communications

CLINICAL LECTURE.

ERYTHEMATOUS ECZEMA.

BY JOHN V. SHOEMAKER, M.D., LL.D.,

Professor of Materia Medica, Therapeutics, Clinical Medicine, and Diseases of the Skin, in the Medico-Chirurgical College and Hospital, Philadelphia.*

Gentlemen: Here is a patient who is suffering indescribable agony from one of the most common diseases of the skin. He is 71 years old, nativity Ireland, and by occupation is a laborer. His chief symptoms are pain and a most irritating itching and burning of the skin over his entire body. He is exceedingly nervous, due to insufficient sleep and rest, owing to the annoyance of his skin. He eats fairly well, the bowels are regular, but complains of eructation of gas after meals, and has much flatulence.

Family History.—His parents both died when he was an infant. He came to America at the age of 8 years, and thus claims he has no knowledge of his family, except one aunt, who died of nephritis at the age of 68 years.

*Delivered in the amphitheater of the Medico-Chirurgical Hospital.

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Previous Personal History.—As a child he had scarlet fever, whooping cough, and diphtheria. At the age of 16 years he had typhoid fever, and influenza at the age of 32 years. He denies venereal diseases.

Social History.—He is married and has two sons and one daughter, all of whom are in good health. His wife died five years ago from an attack of pneumonia. He has his home with one of his sons, and claims that no other one in the family has or had the same disease.

Habits.—He drinks alcoholic beverages excessively, and occasionally takes a two weeks debauch, during which time he eats very little food. He also smokes much and drinks large quantities of coffee and tea with his meals.

Present Illness.—This dates back five years, when he had rhus poisoning of his hands and face. After the rhus poisoning the skin of his hands and face remained red, delicate, and desquamated. It soon began to itch, and he felt a sensation of warmth, followed by a burning of the affected parts. Three months after the rhus poisoning he was on a three weeks debauch of drinking, after which he noticed that the reddened condition of his hands spread up over the forearms and from the face to his neck. Gradually it passed over the body and arms, and at the end of a year's time his lower limbs were also involved. The skin over his entire body felt excessively warm, and at times itched very much, and was worse during the winter than the summer. He sought medical advice and received relief for some time. About two years ago he had a severe attack of itching and burning of his body, and after two months treatment was much improved. Six months ago he had his usual three weeks debauch, the result of which is the present condition of his skin. As you can see, his entire surface is involved, even the scalp and conjunctivæ of his eyes. To the touch the skin is dry, harsh and hot. Desquamation, excoriation, exudation, incrustation, and infiltration are present all over his body. He looks unlike himself and is in a most deplorable condition. In fact, he looks as though he were parboiled. His pulse, respiration and temperature are normal.

Diagnosis.—The diagnosis of erythematous eczema from the

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history, its course, the symptoms, and from the eruptions present in this patient is quite easy. The color in many patients having this disease is subject to many variations, which depend largely upon the exciting cause, the condition of the system, the seat of the eruptions, and the susceptibility of the patient's skin. In fact, the color of redness in some patients is almost imperceptible to the naked eye, the chief evidence of the disease being the intense itching and burning of the skin. The color of this patient's skin is of a violacious hue. In long standing eczemas the skin may often take on a yellowish complexion.

Erythematous eczema may be mistaken for erysipelas, but a differential diagnosis as tabulated on the blackboard will readily give you the distinctive differences.

Erythematous Eczema.—

(1) No history of contagion.
(2) No prodromal symptoms.
(3, Vesicles occur in patches if present.
(4) Eruption fades imperceptibly into healthy skin.
(5) Affected skin is scaly and somewhat infiltrated.
(6) Color bright or dull red.
(7) Pain is itching and burning in character.
(8) Course of disease is chronic.

Erysipelas.—

(1) History of contagion.
(2) Prodromal symptoms, onset with chills and fever.
(3) Vesicles are discrete.
(4) Eruption sharply defined.
(5) Affected skin is glassy and œdematous.
(6) Color purplish.
(7) Pain is acute burning in character.
(8) Course of disease is acute.

Pathology.—After the eruption has existed for some time, the skin, by reason of the interference with the free action of the glands, has a peculiar hard and rough feel, caused by the absence of the normal unctious material, giving rise to desquamation. The characteristic redness and sensation of warmth in the acute stage is due to capillary engorgement. The variation of color

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often present in this form of eczema is due to the rythmical contraction and dilation of the capillaries, which is followed by cell-proliferation and infiltration.

Etiology.—It is probable that the irritated condition of the skin, due to the rhus poisoning, was the first exciting cause of this man's eczema, but I also believe that the chief cause of this aggravated eczema all over his body is due to his debauches and the indiscretion of diet. His gastro-intestinal mucous membrane, with its contained glands, is almost entirely inactive, as evidenced by the dry condition of his tongue.

The alcohol also had its destructive influences on the heart blood-vessels, lungs, liver, and kidneys as well, causing a diminution of the normal secretions and excretions of the body. The retention of waste products, which are eliminated by the liver and kidneys alone, are sufficient to cause such a condition of the skin as you observe in this patient.

Treatment.—The patient is kept at rest in bed, his diet is only milk. Thus far he has had a tenth of a grain of hydrargyri chloridi mitis every half hour for twenty doses, which was followed by an ounce and a half of a saturated solution of magnesium sulphate. In addition internally he is receiving vini antimonii m. x. every three hours in water.

Externally to allay the itching and burning sensation we apply locally with a sponge a combination containing:

℞ Creosoti (beechwood) .....m x
Magnesii carbonatis .....3 ss
Zinci carbonatis .....3 vi
Glycerini .....f 3 i
Liquoris calcis .....f 3 iv
Aquæ hamamelidis q. s. ad.....f 3 viii

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OBSTETRICS.

BY E. S. M'KEE, M. D., CINCINNATI.
Lecturer of Clinical Gynecology, Medical College of Ohio; University of Cincinnati.

PREVENTION OF PUERPERAL MASTITIS.

Doederlein (Zentralblatt fuer Gyn.) recommends the painting of Gaudein's solution of rubber in benzine over the nipple and areola of the nursing woman. The area is then powdered with sterilized talc or meal, and an elastic covering is made which is quite enduring. It may be washed in warm water or alcohol, as it is soluble only in benzine or ether. The author has used it in 200 cases as a preventative of cracks and fissures and the mastitis that often results from these. The infant does not object to the taste, and nurses without objection, or, if preferable, a glass nipple may be used. Any germs that may be on the brush die in a few days, as the mixture contains a 1 per cent. of formalin. The breast is disinfected and dried before applying the solution. This solution has also been found of great benefit in abdominal operations, to increase asepsis. The author reports his laparotomy patients as able to be up on the third or fourth day, so rapid is the healing of the wound. It is of great use in severe carcinoma operations; also to prevent erosion of the skin by irritating secretions, as in urinary and fecal fistula.

ECLAMPSIA, NEW METHOD OF TREATING THE SEVERE FORM.

Sippel (Berliner Med. Wochenschrift) recommends decapsulation of the kidneys, or incision of the capsule in severe cases of puerperal eclampsia, in which, after delivery, the coma and convulsions continue. In these cases practically no harm can be done the patient, since death is imminent if the condition is not relieved. No blame can be placed on any treatment that gives

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any hope of relief. The author believes that the faulty condition of the kidneys, which causes the convulsions to persist, is due, in the great part, to the obstruction of the general circulation and the circulation of the kidneys itself during the convulsions. This increased pressure is not relieved after labor is concluded, and something must be done at once to relieve it. The author recommends that the capsule of the kidneys be incised to relieve this pressure. He has found the operation successful in four cases. It should not be employed for every case, since many are relieved by ordinary measures. It should be confined to those serious and hopeless cases, in which the coma or convulsions continue without relief from other means.

VAGINAL OPERATIONS FOR ANTEFLEXION.

Coffee (American *Journal of Obstetrics,* September) describes an operation for the relief of anteflexion which consists of pulling the uterus well down either with a bullet forcepts or a specially constructed tenaculum, invented by the author. The second step is the incision of the posterior vaginal wall as for vaginal section. The peritoneum is not opened by the author, but is pushed up far enough to expose the posterior border of the uterus; opposite the point of flexion a traverse V-shaped section is removed from the posterior wall of the uterus; this is closed by chromicized twenty-one day catgut. The uterus is replaced and the incision of the posterior vaginal wall closed. It would seem that an additional step might be added to this operation, namely, the opening of the peritoneum and the examination of the adnexa before the incision is made in the uterine wall. The author only reports five cases, which report is altogether too small a number to judge of the result.

AN UNUSUAL CASE OF SARCOMA OF THE UTERUS.

Von Wenczel (Zent. f. Gyn.), says: The ratio of frequency of carcinoma to sarcoma of the uterus is placed at twenty-four to one, and the site of sarcoma is mostly in the corpus uteri. For

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each time that sarcoma begins in the cervix there will be eight cases in which it will be found to have begun in the corpus. They start more often from the mucosa than from the outer wall of the uterus, and when from the latter origin they are usually the result of a degeneration of a fibro-myoma. The sarcomata developing in the uterine wall show the spindle-celled variety as occurring four times more frequently than the round-celled. Of the latter, the small-celled type is much rarer to meet than the large-celled type.

The author's case occured in a woman forty-six years old, who had given birth to two children, and who, since two years, had complained of irregular menses. An ulcerated tumor of the cervix, the size of a child's fist, was discovered, and after curettage the cervix was amputated. Microscopical examination of the tumor proved it to be a sarcoma, and two weeks later the uterus was removed by vaginal hysterectomy. The operation was successful.

The microscopical investigation established the diagnosis of small type, round-celled sarcoma. The connective tissue of the mucosa was inflamed, and this inflammatory infiltration passed into the tumor without showing any sharp line of demarcation. No evidence of fibro-myoma was visible. Hence, the origin of the tumor was decided to have been in the cervix. From the inflammatory condition of the connective tissue of the mucosa it is also assumed that the tumor developed not from the mucosa, but from the wall of the uterus itself, and was a primary growth.

SUBCUTANEOUS EMPHYSEMA DURING LABOR.

Gilles (*Provy Med.*) reported a case of the above to the Clinical-Anatomical Society of Toulouse. A primipara, thirty years of age, after about three hours of the second stage of labor, felt suddenly, during a strong expulsive effort, a sensation of tearing in the thorax, which was followed immediately by an enormous distension of the skin of the neck and face. Aphonia and some slight embarrassment in swallowing, accompanied this manifestation, and the doctor on his arrival was able to diagnose at once

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what had occured, aided by the characteristic crepitation. Labor was terminated by instrumental interference, and the emphysema soon disappeared, although the crepitation could be perceived for some time afterwards on careful palpation.

A Case of Criminal Abortion.

A. Schonbek (*Zent. f. Gyn.*) reports the case of a patient who had given birth to three children spontaneously, and one miscarriage. She had been pregnant three months, and was brought to the hospital suffering from chills and fever. The os was still closed and the uterus corresponded in size to that of three month's pregnancy. Because of irregular uterine hemorrhages the cervix was first dilated with the Fritsch dilator and followed by the insertion of a laminaria tent. Chills and fever with vomiting on the next day. Removal of fetus and placenta with finger and forceps, followed by lysol irrigation. Peritonitis progressive up to death, three days later. Autopsy discovered beneath the liver an elastic bougie, broken, and 13 cm. long.

Labor in a Case of Excessive Hypertrophy of the Cervix.

Haagu (*Zent. f. Gyn.*) mentions the case of a patient, a primipara thirty-four years of age, who had suffered from a prolapsed hypertrophied cervix during twenty-one years. The labor was difficult, requiring an anterior cervical section with the application of forceps. After that, everything followed a normal course.

Phantom Pregnancy in a Forty-eight-year-old Multipara.

Krummacher (*Zent. f. Gyn.*) reports the case of a woman forty-eight years old, and mother of five children. Previous pregnancies normal. Periods regular down to August, 1901. September period skipped and that of October slight; again absent until a slight show appeared in January, 1902. Excepting a slight show in February, nothing developed up to the time of

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examination in the middle of May. Abdomen, hips and breasts enlarged. For eight weeks the woman had felt distinct movements and knew that she was pregnant.

Examination revealed a distended abdomen, on the right side of which lively jerking movements were visible, and proved to be located in the right rectus abdominis muscle as well as in the oblique muscles. No intra-abdominal tumor discoverable. Internal examination showed an old lacerated cervix with uterus not enlarged. Adnexa and parametrium normal. Moderate amount of colostrum in the breasts. Patient refused to reject the idea that she was not pregnant. The case was diagnosticated as one of "idiopathic (chronic) contraction of the abdominal muscles." After some argument the patient was finally convinced of her error, and cured in a short time of the muscular contractions by sea baths.

Gonorrhoea in Women.

Dr. A. Routh (*Clin. Jour.*) points out the fact that, in women, gonorrhœa is one of the most serious diseases, because of the danger of the internal pelvic organs becoming involved. He regards it as far more serious in a woman than syphilis, as a husband with an apparently cured gleet may keep on reinfecting the wife, for a single attack of gonorrhœa does not render the patient immune. Again, the woman may have her endometrium reinfected after being cured, by discharges from a gonorrheal salpingitis. Clinically the disease manifests itself either acutely or insidiously.

In the acute variety, after a period of incubation covering three to five days, there are first noticed heat and dryness of the parts, with swelling, tenderness and painful micturition. An irritating, thick, purulent discharge makes its appearance in about two or three days. Most of these conditions quickly abate, but leave the vagina bright red, the portio bright red, with pus oozing from the cervix. Thus within a week vulva, vagina, endocervix and urethra are all inflamed. At the end of ten days or a fortnight the discharge will grow less, or pass on into the chronic form,

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or lead to endometritis, salpingitis, perimetritis, or other complications.

The insidious form comes on, as a rule, in a newly-married woman whose husband has had gleet for many years, which for some time had been supposed to be cured. It may assume an almost undiscoverable type and be demonstrable only by the discovery of a few lurking gonococci in the cervix and endocervix, which, apparently, produces no symptoms in the patient.

Regarding treatment, an attempt should be made, as soon as the acute stage is a little lessened, to stop the further progress of the diseases. Under anesthesia, by preference, the vagina is douched and the cervix drawn down. A strong solution of liquor iodine (1 in 9) is applied to the endocervix as far as the internal os. To the whole vagina a nitrate of silver solution (3 i to ℥ i) is next applied through a Fergusson's speculum, and the same solution in painted over the whole of the vulva. This still leaves the urethra to be treated. On a Playfair's probe, pure carbolic acid is introduced into the urethra, and one application rarely fails to cure. Although one treatment may cure the patient, the procedure sometimes has to be repeated in five or six days.

If the catarrh is very bad, give oil of yellow sandalwood in fifteen-drop capsules, three times a day; or salol (gr. v., t. i. d.); or urotropin (gr. vii., t. i. d.). These drugs are directed toward a persistent urethritis. The patient should be douched every day—plain water or boric acid solution at first; later, lead or sulphate of zinc solution (3i-Oi).

The diagnosis should be based on the history of the case, clinical course, and presence of gonococci. It is usually better, in medico-legal cases, merely to state the strong probability rather than the certainty of the presence of the disease.

The complications of gonorrhœa may be endometritis and metritis. To prevent the further spread of the infection, a strong application of iodine to the uterine interior, preceded, perhaps, by a curettage, is advised. Every second day for a week or two, a fresh piece of gauze dipped in iodine and glycerine should be applied to the endometrium.

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Another complication is salpingitis, which may lead to pyosalpinx, and, if bilateral, to permanent sterility. Pus-tubes should be incised per vaginam and drained. Such tubes often recover themselves. Salpingitis occurs in 33 per cent. of women who have gonorrhœa. Ovarian abscesses have been described. Ectopic gestation may occur in gonorrheal tubes. Rarely general peritonitis, but frequently local pelvic-peritonitis is found. Venereal warts sometimes appear, which require snipping off and the actual cautery, then dust salicylic acid and oxide of zinc (1to 2) over the parts. Buboes, urethritis, cystitis, bartholinitis, proctitis, ophthalmia, gonorrheal rheumatism or puerperal fever, may supervene as complications.

Clavin in Obstetrics.

A. Labhardt (*Muench. med. Woch.*), of the Woman's Hospital, at Basel, has investigated the action of calvin in a number of obstetrical cases. Clavin is an active principle of ergot, is soluble in water, and clinical reports are to the effect that it does not cause gangrene or convulsions, but stimulates the uterus to active contraction. It can be given by mouth or subcutaneously. In eleven cases of ineffectual labor pains, strong contractions of the uterus resulted in all but one patient. It was generally necessary, however, to repeat the usual dose of 0.02 (one-third grain) two or three times. Clavin was also used after child-birth in a series of cases, and the desired action was, as a rule, very prompt; in some cases it was necessary to repeat the dose or to resort to other uterine tonics.

Clavin, the author states, acts well also as a prophylactic against hemorrhage, where an instrumental delivery is contemplated. If compared with ergot, it will be found that clavin is equally as effective, and possesses the advantage that it may be used even before expulsion of the fetus, and that it is entirely free from toxic properties.

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Blood Examinations in Puerperal Fever.

Knowatzki (*Beitrage z. Geburtsh. u. Gynak.*) offers the following resume:

1. Prognosis favorable: Slight or no change in the neutrophile blood picture; presence of eosinophiles.

2. Prognosis unfavorable: Leucocytosis of 50,000, severe change of the neutrophile blood picture; absence of eosinophiles; marked decrease of red blood corpuscles.

3. Improvement: Improvement of the neutrophile blood picture; reappearance or increase of eosinophiles.

4. Change for the worse is indicated by marked alteration of the neutrophile blood picture and diminution or disappearance of eosinophiles.

5. Prognosis absolutely bad: Occurrence of poikilocytosis associated with polychromasia and nucleated red blood cells.

In conclusion, the author suggests whether those leucocytes in which phagocytosis is observed belong in the multinucleated groups—five, four, three, or not. It it is true that these cell groups disappear from the circulation because they were used in the combat against infection, we would expect again to meet them as phagocytes.

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Selected Articles

The Surgical Treatment of Renal Tuberculosis.

BY. F. S. WATSON, M. D., BOSTON.

The question of the surgical treatment of renal tuberculosis may be summarized thus:

1. *Nephrotomy* is of service as a palliative measure for the purpose of evacuating pus retained in the kidney and for the relief of pain and fever due to such retention when it occurs in cases in which nephrectomy if contra-indicated. Other than this, nephrotomy has no place in the surgical treatment of this condition.

2. *Nephrectomy, when performed under proper conditions,* is the *only* form of treatment of whatever kind by which we can hope to *cure* any important number of cases with this malady.

What are these proper conditions? They are as follows: (*a*) That the tuberculous infection does not involve both of the kidneys. (*b*) That there are no tuberculous lesions elsewhere in the body of such extent or involving such organs or structures as to render the performance of nephrectomy useless, because of their existence. (*c*) That the functional capability of the kidney to remain, after the performance of the nephrectomy, shall have been established beforehand.

When these conditions are present, nephrectomy will result in the *cure* of from 25 to 30 per cent. of the patients, and at an operative risk of from seven to ten per cent.

This statement is made upon the strength of the series of more than 300 cases reported by Casper, Rafin, Albarran, Fenwick, Kummel, Kuster, Kelley and Israel, in which about this percentage of cure was obtained, as shown by the fact that there was no evidence of tuberculous infection in the remaining kidneys of this proportion of the patients, examined at intervals of from one to ten years after operation.

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How often *is* tuberculous infection confined to one of the two kidneys, and can we demonstrate with reasonable certainty its presence in one and its absence in the other of them?

Tuberculous infection of the kidney at the outset, is confined to one of the two organs in the large majority of female patients and in probably more than one-half of the males.

The evidence upon which this assertion rests is as follows: In 37.6 per cent. of all the cases of renal tuberculosis found in a series of 13,000 *autopsies* made at Kiel in Germany, the infection was unilateral.

Surgeons having the widest experience in the treatment of this condition are substantially agreed in estimating the proportion in which the infection is confined to one of the two kidneys in from 60 to 80 per cent. of the patients examined early in the disease.

The means employed to determine the presence of the disease in one kidney and its absence in the other consists in testing the urine drawn from each kidney separately with ureteral catheters. These tests being to determine the presence of tubercle bacilli, of pus and blood, and by inoculation.

One other diagnostic evidence of the presence of the infection in the kidneys deserves special mention. I refer to the cystoscopic appearances of the orifice of the ureter of the infected kidney and of the part of the bladder immediately adjacent to it, which appearances are so characteristic to those surgeons who are thoroughly familiar with them—Hurry Fenwick, Willy Meyer and some others—that they are all that is needed for them in order to make an absolutely positive diagnosis of tuberculosis of the corresponding kidney.

A striking opportunity was offered to Mr. Fenwick for proving the correctness of this assertion and is published by him recently in the form of a clinical lecture which he delivered to students and medical men.

In the course of this lecture, he showed a woman who presented none of the usual evidences of the existence of renal tuberculosis; that is to say, she had no fever, loss of weight or strength, neither kidney was enlarged or tender. The urine contained no pus or renal elements, and repeated expert examina-

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tions failed to discover tubercle bacilli. Cystoscopic examinations, however, revealed the conditions shown in the two figures which I pass around for your inspection, and which are taken from the article of Fenwick.

Upon these appearances solely and only, Fenwick not only positively asserted the existence of tuberculous infection of the corresponding kidney, but also stated that he was equally confident of the exact location and extent of the process in the kidney and ureter. He next demonstrated the cystoscopic appearances to a number of his audience, and then showed them a sketch of what he expected to find in the kidney upon its removal, which sketch he had made several days before and which I will also pass around. Finally he removed the kidney without opening it, and upon doing so after the operation, his prediction with regard to the extent and location of the disease as shown by the sketch previously made by him, was verified in every respect.

Cystoscopic fallacies.—I may here appropriately speak a word of warning with respect to reports of the findings with the cystoscope made by those who have not had a very extensive and long experience of such examination, for the fallacies and errors of cystocopy are numerous, and no better testimony of the truth of this can be furnished than that of Fenwick himself. In the course of a chapter devoted to these fallacies and errors in his very interesting volume published in 1904, and entitled "Clinical Cystoscopy," Fenwick refers among other cases to three of his own, in which he opened the bladder for the purpose of removing tumors which he was positive of having seen with the cystoscope, but in none of which was the slightest trace of the tumor to be found.

Elsewhere in reporting the cystoscopic examinations in a series of 150 cases of tumors of the bladder, he remarks that he throws out the first fifty of these as useless because of their having been made at a time previous to that at which he had learned to interpret correctly what he saw, or to see all that there was to be seen.

If one of the first if not the first cystoscopist of our time in

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point of skill and experience says this of his own experience, it is evident that the results of such examinations made by those who are less experienced should be taken with some reserve.

With regard to the influence exercised upon our decision as to whether nephrectomy should or should not be done, by the presence of tuberculous lesions elsewhere in the body than in the kidneys, it will depend, as has been said, upon the structures involved by them and upon their extent. We should not, for example, do a nephrectomy upon a patient with widespread tubercular infection of the lung, nor again, in a case in which the prostate and bladder were involved; but on the other hand, nephrectomy is the best treatment for tuberculosis of the bladder in the case of women, when both these organs are involved in the process provided one kidney only is involved.

Moderate lesions of bone or lungs do not constitute contra-indications to the performance of nephrectomy.

With regard to establishing the functional sufficiency of the kidney that is to remain after nephrectomy, the means for so doing are too well known to need more than a passing reference. I will only say with regard to this part of the subject, that of the more recent tests by which functional capability of each kidney individually is ascertained, that of cryoscopy is, I believe, the most reliable, and is of real value. None of the ways of segregating the urine in the bladder thus far devised seem to me to be reliable or to compare in value with ureteral catheterization.

The value of the cryoscopic, phloridzin and other recently devised tests is well shown by the comparison of two series of 362 and 292 nephrectomies, in the former of which the tests of functional capability of the other kidney were not applied, and in which the operative mortality was 35 per cent. and the latter of which the tests were applied, and the operative mortality of which was 7.8 per cent.

To recapitulate we may say this:

1. The kidneys are the first of the genito-urinary organs to be involved in the infection in a considerable proportion of male patients, and in a majority or females.

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2. That the infection at the outset and for variable periods afterwards involves but one kidney.

3. That we are almost always capable of determining the presence of the infection in one kidney and its absence in the other, when such is the case.

4. That we can determine the functional capability of the other kidney in almost all cases.

5. That nephrectomy performed in cases in which the infection is confined to one of the kidneys, and in which the functional capability of the other one has been demonstrated, yields from 25 to 30 per cent of cures.

6. That the operative mortality when nephrectomy is done under the proper conditions is about eight per cent.

It is true that this is not a very brilliant showing, but it becomes so in view of the fact that no other form of treatment gives more than four per cent. or so of cures, which I say upon the strength of an inquiry made by me personally a few years ago, in which I addressed questions with reference to this point to members of the American Climatological Association and some other general practitioners, and upon the fact that pathologists tell us that they rarely if ever see examples of spontaneous healing of tuberculous lesions in the kidney other than in the comparatively small number in which the process has been terminated by total destruction of the organ through extensive suppuration or occlusion of its ureter, which is not healing in the proper sense of the word.

Whether or no we shall discover an antitoxin which shall be as beneficent in cases of tuberculosis as that which has robbed diphtheria of its dangers, we do not know. Until such discovery has been made, we must turn to nephrectomy as the only means by which *cure* can be obtained in a considerable proportion of the patients. The measure of success obtained will depend upon the operation being done at an early period of the malady. One of the most important objects to be sought is therefore to make the physician realize the necessity of early diagnosis and early delivery of the patient to the surgeon for operation.

As it was with appendicitis and in a measure still is, as it is

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with cases of prostatic hypertrophy, of gallstones and cholecystitis, or renal calculus and other maladies, the tendency of many minds in the profession is to temporize, and under the soothing narcotic belief and self-commendation of being conservative and safe, to treat the patients with palliative measures so long as they are not in immediate danger or are not actually suffering. In the presence of danger and of pain or at the final insistence of the patients themselves, they are at length brought to the surgeon at a time at which their malady has long since passed the stage at which surgical intervention could have saved or greatly benefited or cured them. Renal tuberculosis is another example of the cases which surgery cannot be expected to benefit in any important degree when it is in its later phases; it can be looked to to cure at least 20 per cent. of those who are brought at or near its inception, and will prolong life and spare suffering of a still larger proportion under those circumstances. Moreover, up to the present time it is the only treatment which can accomplish anything worth mentioning in the way of cure, and though its resuits are not brilliant, we may say that they are at least twenty times better than can be hoped for them from any other course known to us.

I have purposely spoken with reference only to the essential features which concern the application of nephrotomy and nephrectomy in cases of renal tuberculosis, and of the latter operations, only in so far as its curative power is concerned, thinking that to enter into any other parts of this most interesting subject would lead me too far afield. Just one other point I should like to touch upon; it is with reference to what nephrectomy may do to benefit patients in the cases in which we do not look for cure because of the fact that both kidneys are already involved. Nephrectomy is not positively contra-indicated in all of these, and in some of the cases in which I have done the operation myself under these circumstances, and in some in which I have had the opportunity to see something of the results of the operation when done by others, I have found great temporary benefits result from it.

The indications for taking out one kidney when the other is

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slightly affected are when the seriously damaged kidney is the seat of extensive suppuration, is causing a great deal of pain and high temperature and when, for any reason, it is better to run the greater danger to life from the performance of a nephrectomy than to have a fistula to care for after doing a nephrotomy

A Few Notes on a Few Cases of Renal Tuberculosis.*

BY PAUL THORNDIKE, M. D., BOSTON.

Your secretary has asked me to present this evening a short paper on renal tuberculosis. It is an important subject, interesting alike to the physician and to the surgeon; to the former, because of the difficulties and imporance of diagnosis in the early stages of the disease, and because of the gradually growing realization that some such early cases may be properly and successfully treated by non-surgical means; to the latter, because of the brilliant surgical results to be obtained in properly selected cases, and because of the dependence of these results upon such proper selection.

Up to 1880, although the disease was well known, pathologically speaking, it was not included in the schedules of those diseases which are well recognized clinically as subject to accurate diagnosis. Since that date, its clinical picture, during the various stages of its development, has been made more familiar to us, its frequency of occurrence has been recognized more completely, and its accurate treatment has been a gradual evolution of the last ten or a dozen years.

It would not be possible, nor is it the writer's intention, this evening, to make a complete resume of our present knowledge of this disease, but rather is it his desire to emphasize a few points which have arisen in his personal experience with such cases.

It has come to be known during the last few years that genito-urinary tuberculosis is a common disease, and that it occurs in the kidney, epididymis and in the Fallopian tubes with about equal frequency. It starts not uncommonly in the prostate but, so far as we know, less frequently there than in the

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kidney or epididymis. The disease is not usually primary in the genito-urinary system, but has a focus in some other part of the body, from which the infecting material is carried to the kidney or other genito-urinary starting point, in the blood stream; so that no matter how early in the process of the renal or other lesion we are fortunate enough to make a diagnosis, we must always remember that we are not dealing with the only focus of disease which the body contains. There are, of course, exceptions to this, as to most other rules. In the writer's experience, a prostate, which was removed for other reasons, was found to be tuberculous, and upon the patient's death some time later, from other cases, this tuberculous prostate was found to have been the only tuberculous focus in the body, and was, therefore, the primary disease not only for the genito-urinary system, but for the whole body. Renal tuberculosis, then, is a fairly common disease, and Bevan states, in an admirably practical article recently published in the *Journal of the American Medical Association,* that "in surgical clinics, in which kidney fixations are limited to suitable cases, tuberculosis of the kidney usually furnishes the largest percentage of any single pathologic process, being more frequent than stone or tumor." Of the fifty operative renal cases in the writer's personal records, seven were tuberculous.

After the renal infection takes place, it has been found that, for a considerable period of time, in most cases the process is limited to this one kidney, and with the cystoscope and other modern aids it is possible in many cases to make the diagnosis before further extension of the disease has taken place.

We are dealing, then, with a disease which, although not usually primary for the whole body in the kidney, has its most important focus of infection in that organ, and is limited to that organ long enough after its inception to make a diagnosis, with the means at present at our command, possible during this period. These facts seem to be proven to the universal satisfacton of students of this disease, for although autopsy records show an enormous percentage (certainly over 50 per cent) of bilateral renal tuberculosis, clinical records, from modern surgical clinics,

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have shown during the last ten years a very small percentage (none over 15 per cent.) of bilateral cases at the time the diagnosis was made.

From these facts, then, we should infer that with a diagnosis made while the disease is still unilateral, brilliantly successful results should follow removal of the infected kidneys, and such has already proved to be the case.

Primary nephrectomy in proper hands for this disease seldom proves fatal, and the after-result at this stage of the development of the disease is all that may be desired. What cases should be so treated? In reading reports of some cases where a diagnosis has been made very early in the progress of the disease, made perhaps by the lucky finding of the few bacilli in the urine from one kidney or the other, in a patient where the symptoms of irritation, etc., were all referred to the bladder and where there was nothing to suggest renal involvement until the ureters were catheterized, it is perhaps fair to speculate as to whether the brilliant cures which followed nephrectomy might not be equally brilliant following a proper hygienic and climatic treatment in similar cases. In this connection, the writer has been interested to note a statement of Dr. Edgar Garceau's in a paper recently published, which is as follows: "Incipient tuberculosis of the kidney is best treated by a change of climate, but, unfortunately, incipient renal tuberculosis is rarely diagnosed, and it is only when the disease is well along and has invaded the rest of the urinary tract that the diagnosis is usually made. If it has not gotton too much of a start, and this may be fairly accurately determined by the amount of pus in the ureteral urine, it is worth while to try the effect of climate." Now it may be true that such early diagnoses are seldom made, but it is getting less true all the time, and it is put to the surgeon to have an opinion on this question and to decide what is to be done with these patients when such an early diagnosis is possible.

Every year the profession proves itself wider awake to the frequent occurrence of this disease, and every year more and more early and accurate diagnoses are made. In the last few weeks, the writer has seen in consulation three cases—all referred to him

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as possible cases of renal tuberculosis by physicians in general practice. The fact that only one of the three proved to be of tuberculous origin does not alter the fact of the physician's recognition of the possibilities, nor does it undervalue his promptness of action. Of seven personal cases of the writer's, four were operated for the removal of the kidney; all of these recovered and did well. Of the three other cases, one was never operated because of her own refusal, and the other two were deliberately treated by change of climate and hygiene after an early diagnosis was made. One of these patients is a young girl who (two years after the diagnosis was made) is now in good health. Her physician writes that, although the urine still shows the same evidence of disease as formerly, he cannot see that she has progressed beyond the point reached two years ago. The other is a clergyman who writes from the mountains of California that he has forgotten he ever had anything the matter with him, and that he is told his urine no longer shows the bacilli of tuberculosis. In one of these cases, operation had been vigorously insisted upon by other advisers.

The point is this: While it is true that nephrectomy results are brilliant and that the bulk of the patients presented to us come at a stage of the disease where few surgeons would hesitate to operate, the incipient case, with little or no pus in the urine, is becoming more and more quickly suspected by the physician and, therefore, more frequently recognized by the surgeon. In such cases, frequent or infrequent though they be in the experience of any one of us, hygiene and climate should have a chance before the surgeon removes so important an organ.

Now to consider the later cases. Nephrectomy is always the operation of choice. For years many pus kidneys have been approached through the loin and drained. Many of these have, doubtless, been tuberculosis kidneys. All surgeons are familiar with the stubborn persistence of these loin sinuses resulting from nephrotomy for pus kidney, from stone or some other cause. All surgeons dread the care of them just as they dread the care of the empyema sinus, and patients may well dread the possession of them. The writer never does a nephrotomy for pus kidney with-

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out wishing that nephrectomy were the possibility instead, and as the years go by and the number of his secondary nephrectomies accumulates, he is more and more prone to make the nephrectomy a primary procedure. In these tuberculosis cases he believes that nephrotomy is never indicated, except for the relief of pain and the evacuation of pus in far advanced cases which cannot be subjected to the more radical operation. He also believes that nephrectomy should be done in all cases where the patient is strong enough to bear the operation, even when portions of diseased tissue are left behind. We all realize that even in comparatively early operations, where the local focus is removed with apparent completeness, we are still leaving behind another (the primary) focus elsewhere in the body. We all realize when we cut open and clean up a tuberculosis joint that we are not removing all of the disease, and yet we often get a good stiff joint and a complete healing. It has been the writer's experience to remove tuberculosis testes, knowing that he was leaving behind infected vasa and often infected prostates, and then to see the remnants of the disease die out, leaving the patients apparently free from further trouble. It has been his experience to see tuberculosis ulcers in the bladder heal themselves after the infecting kidney was removed, and to see, in one case at least, the remains of an infected ureter stump shrivel down and heal itself after a nephrectomy which removed so much of the diseased tissues as the patient's condition would stand. Therefore, he believes that, while every emphasis should be placed upon the necessity for completeness and thoroughness of the operative technique, the removal of ureter as well as the kidney, whenever possible, and the absolute necessity for leaving behind no part of the disease which is safely removable, the surgeon should not be discouraged, nor should he hesitate to operate, because he knows or perhaps learns, after his incision of approach is made, that the disease has passed the point which limits its complete removal.

Now, let us consider for a moment the question of the other kidney. It has already been stated that autopsy statistics show in a large percentage (over 50 per cent) of renal cases, both organs involved, while clinical statistics in these later years show the

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diagnosis made at the time when only one kidney was involved, less than 15 per cent of the patients presenting themselves having the infection in both organs.

Bevan, in his recent article already mentioned, notes figures as follows: 12,732 autopsies at Kiel showed that of the cases of renal tuberculosis 62.3 per cent were bilateral and 37.6 per cent unilateral; or, roughly speaking, two out of three cases had involvement of both kidneys.

On the other hand, the clinical statistics show as follows:

Kroenlein showed 92 per cent with only one kidney involved; 8 per cent where both organs were involved; Israel showed only 8.3 per cent bilateral involvement; Facklam showed only 9 per cent bilateral involvement; Kummel showed only 12 per cent. bilateral involvement.

In these bilateral cases, however large or small their number, the question at once arises, Shall we remove a badly diseased kidney in the face of the knowledge that the other kidney is beginning to be involved? It is, of course, unwise to make sweeping generalizations concerning questions not subject to proof, but one may always be permitted an opinion. The writer's opinion is that any large tuberculosis focus which is so readily removed as is a kidney should be at once so removed in every instance where the patient's condition will stand the removal, and where it has been possible to get a fairly accurate knowledge of the working capacity of the other organ. With a full recognition of the many difficulties attending the use of ureter catheterization, especially in the male, with a realization of the many limitations and sources of inaccuracy attending the employment of cryoscopy, the phloridzin and other similar tests in ascertaining the relative work-capacity of the two organs, the writer believes that in most cases it is possible to find out not only which kidney is the chief offender, for usually by the time the second kidney is involved at all the first is very evidently so involved, but whether the other kidney is capable of doing the work of both with a fair degree of success; and he earnestly believes that the simple fact of the known involvement of the second kidney does not always remove the necessity for and the propriety of a nephrectomy upon the

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organ chiefly involved. He is strengthened in this belief not only by the fact that many such nephrectomies have been done in the past, often without the knowledge of the operators, but also that his own experience is constantly showing him, with more and more clearness and insistence, the fact that the removal of a large part of the tuberculous infection is often the turning point in the progress of the disease and enables the patient to handle the remaining portion in a way that would have been otherwise quite impossible.

To sum up, then, the writer believes that in the comparatively small but constantly increasing number of patients where the diagnosis can be made before much destruction of kidney tissue or involvement of other organs has taken place, hygiene and climate should have a chance before the kidney is removed. He believes that this treatment will often do away with the necessity for an operation. For the more numerous later cases nephrectomy is always the operation of choice, and should be done in every instance, if the patient can stand it, and if he has another kidney capable of doing a fair amount of work, whether the disease has passed beyond the limits of the organ or not, and whether the other kidney be involved or not.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

Acute Edema of the Pharynx with report of a Case Requiring Rapid Tracheotomy.

Goethe Link describes an interesting case of acute edema of the pharynx. The patient had become unconscious. The writer incised the tissues in the median line two inches above the sternal notch. He introduced his finger and worked bluntly to the trachea. He then introduced a knife, edge upward, along his finger. The trachea was then stabbed and cut slightly upward. After the knife was withdrawn, a closed hemostat was introduced into the trachea, was opened, and was pulled out after the manner of treating an abscess. A tube was then inserted. The patient had been suffering with a simple tonsillitis for ten days. The left tonsil had been incised a number of times during the illness. Acute edema developed. After the treatment described by the writer, the edema declined as rapidly as it had risen. Within three hours the patient could talk when the tube was closed and air forced through the natural channels. The recovery was uninterrupted.—*Medical Record.*

The Approaching Conquest of Cancer.

Robert Bell refers to the recent work of Beard in relation to the trypsin treatment of cancer. He considers it of the first importance in the treatment of cancer to aim at restoring the functional activity of the thyroid gland and at the same time to adopt measures which will reduce the tendency to the introduction of toxic material from the intestines. This can be accomplished only by adapting the dietary to the requirements of the body, and to the capability of the digestive organs to completely digest and assimilate the food, aided by the thorough evacuation of the effete matter at least once in the twenty-four hours. The thyroid, however, is not the only organ whose utility is impaired. It

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is likely that the pancreatic secretion is to a certain extent in abeyance, and as a rule, the proportion of hydrochloric acid in the stomach is greatly diminished. The writer believes that cancer is the culminating point in a series of changes in certain important organs, consequent upon a vitiated blood supply which in turn is greatly due to gross negligence of hygienic laws and over-indulgence in unsuitable articles of diet.—*Medical Record.*

H. Wildbolz on the Results of Splitting the Kidney Open As In Surgical Exploration or Operation.

Wildbolz, as the result of experiments upon rabbits and dogs, in which he split the kidneys open and subsequently examined them with reference to the histology pathologico-anatomical conditions, asserts that the amount of injury from this procedure is much less than has been stated by certain other observers (Langemak and Hermann).

In the experiments of Wildbolz the kidneys were exposed in the loins of the animals and split in two by incisions extending deeply into the substance of the middle of the organ.

In some cases the kidney incisions were completely sutured, in others only superficially.

Among the resulting conditions discovered by histological examinations, were the formation of infractions in the surfaces of the kidney incisions. These, however, were limited in extent.

As a result of some further experiments in which Wildbolz injected the vessels, he concluded that the part of the kidney which was least supplied with blood vessels was that which would be divided by a longitudinal incision directly through the middle of the organ, this incision consequently would be productive of the smallest degree of parenchymatous destruction.

The incision employed by him was in the long axis of the kidney, whereas in the experiments of the two other observers mentioned above, it was through the transverse diameter. Moreover, they employed sutures which were passed deeply into the renal parenchyma. It may be conjectured that the more serious disturbances noted by them were due to this fact.

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The comment is made that in cases of moderate renal traumatic lacerations in the human subject, in which autopsies have been made at varying periods, of days, months, or years later, very trifling lesions resulting from such traumatism have been found to exist.—*Boston Medical and Surgical Journal.*

Tattoo Marks.

Variot of Paris proceeds as follows: Apply under antiseptic precautions a concentrated solution of tannin to the skin and work it in as in tattoo operation. Then rub skin with pencil (or solution) of silver nitrate until the tattoo marks stand out as black points on the silver tannate. Excessive fluid should be removed; the surface turns black and moderate inflammation follows. In fourteen days the eschar drops off, leaving a red superficial cicatrix which fades in seven or eight weeks. This plan is safe and sure—but painful and tedious. Ordinary slight tattoo marks (powder marks, etc.) may often be removed by pricking in peroxide of hydrogen. Another plan is to tattoo well over mark with needles dipped in a solution of chloride of zinc thirty parts, distilled water forty parts. Eschar drops in two weeks. Then dress area with simple cerate. The fact that the insoluble substances which are used in tattooing become encapsulated explains the difficulty experienced in their removal. Under the microscope excised portions of tattooed tissue show large particles of pigment situated part in the corium, but more generally in the subcutaneous connective tissue itself. In the method by electrolysis the needle is attached to the negative pole of a battery with a current of from two to ten milliamperes and inserted at various points about the periphery of stained area till reaction is marked enough to insure destruction of involved tissue. The dry superficial eschar falls in a few days and the process may be again employed over the adjacent skin.—*The American Journal of Clinical Medicine.*

EARLY OPERATION IN INTRACRANIAL INJURY.

According to Phelps epidural hemorrhage demands operation in such cases as do not obviously tend to spontaneous recovery,

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or in which a fatal issue is so imminent as to permit no question. Phelps says that meningeal contusion, when productive of symptoms, either cannot be diagnosticated from an epidural hemorrhage, or is indistinguishable from the diffuse cerebral edema with which it is always associated. A recognized intracranial hemorrhage may be expected to be of pial origin when associated with cerebral lesions, and will indicate operation when the cerebral lesion is regarded as of minor importance. Cerebral contusions may be of two kinds: (a) Limited—no tendency to a fatal termination, and never suggests operation. (b) Diffuse—two classes of cases; in one a vascular disturbance incapable of self limitation, not markedly involving the integrity of the cerebral cells, but tending to mechanically destroy their functions; in the other, a progressive disintegration of cellular structure, an active process due to chemical changes, which natural forces prove insufficient to restrain. In the first, operation is theoretically indicated; in the second, in view of the origin and nature of the pathic changes, there is no reason to suppose a simple relief of pressure will stay their progress. In neither is it possible to fix the time when operation may so supplement natural forces and simpler remedial measures as to increase the patient's chances of recovery. In mixed cases—cerebral contusion complicated with pial or epidural hemorrhage—operation should depend on the estimated relative importance of the lesions; and the correctness of this estimate must depend on the acumen and experience of the surgeon.—*Journal of A. M. A.*

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MEDICAL

Influenza in its Relation to Diseases of the Nervous System.

Joseph Collins assumes a conservative attitude in regard to the part played by influenza in the etiology of nervous disorders, and states that experience teaches that the baneful effects of the pathogenic activity of the Pfeiffer bacillus upon the nervous system have been overestimated, and that in reality influenzal and post-influenzal neuroses and psychoses are not very common. The bacillus of influenza may and does cause meningitis, encephalitis, myelitis, and possibly neuritis. The toxins produced by the pathogenic activity of the influenza bacillus are adequate exciting causes of neurasthenia and psychasthenia, of neuritis and neuralgia, of various forms of insanity, of independent nervous symptoms, such as insomnia, vertigo, headache, and they may be contributory to the causation of any disease that afflicts the human being. Nevertheless neither the bacillus of Pfeiffer nor its toxins *i. e.* influenza, is a common cause of nervous disease. The disorders of the nervous system that stand most frequently in causative relation to influenza, are those dependent not upon the direct action of the bacillus of influenza upon the nervous system, but upon the activity of toxins produced by the pathogenic activity of these germs. These are neurasthenia and psychasthenia, neuralgia, and neuritis, and diseases and disorders of the nervous system attending and dependent upon arteriosclerosis.—*Medical Record.*

Further Study of the New Infectious Disease.

L. K. Hirschberg (*Journal A. M. A.*, Feb. 2.), has been able, through the kindness of a number of colleagues, to obtain records of eleven more cases of the peculiar fever, first described by him in the *Journal A. M. A.*, Aug. 11, 1906. It appears from his correspondence to occur throughout the United States, as his reports come from widely separated localities. The disease

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may be defined as an acute infection of sudden onset and unknown bacterial origin, characterized clinically by fever, constipation, absence of blood parasites, agglutination with the usual bacteria, rose spots, enlarged spleen and tympanites. Its pathology is unknown, as there have been no deaths, and there was no way to ascertain its incubation period from the histories; the onset was always sudden. The duration was from 15 to 20 days. Constipation was a conspicuous symptom, and the slowness of the pulse was a striking peculiarity. No epistaxis, chills or sweating. In no case were there any abdominal tenderness or characteristic eruption; the fever was rapidly ascending, reaching even 105.4 without delirium or nervous symptoms in some cases. Cultures and agglutination tests were failures. The diagnosis is simple, there is little chance to confuse the condition with other diseases; it seems, he says, to be a distinct entity. In all cases thus far reported the patients have recovered without apparent sequelae, except one, who had, some weeks later, an attack of typical typhoid with Widal reaction. The general management of the disorder, like typhoid, consists in good nursing, attention to diet and hydrotherapy. The constipation is stubborn and should be closely watched.—*Medical Sentinel.*

E. S. Goodhue states that Hawaii offers a rich field for the study of fevers. In reference to Hawaiian fever, he says that, while the morphological findings are extremely interesting, they are far from conclusive; and the clinical differences are not so marked that they cannot be included under some form of typhoid fever. In regard to malaria, it has been said that the amount of physical incapacity caused among laborers by this disease is far greater than that from all the other diseases combined. Malta fever deserves careful study because its early stages are easily confounded with malaria, while later it closely resembles chronic rheumatism. Among the other fevers which the writer discusses are yellow fever, dengue or breakbone fever, and swollenhead fever.—*Medical Record.*

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The Roentgen Treatment of Hodgkin's Disease, Leukemia, and Polycythemia.

Henry P. Pancoast declares that although conservative men are beginning to look upon the Roentgen specialist as overenthusiastic in his claims, and perhaps with some justice, nevertheless, at the same time, these very men stand willing to acknowledge that the *x*-ray has great value and is the most reliable agent in treating leukemia. Tissue destruction is doubtless the greatest factor in the results accomplished in the *x*-ray treatment of leukemia. In the case of a leukemic patient, the toxic conditions should be carefully studied and the tissue destruction should be investigated before and after beginning *x*-ray treatment. Dangerous effects should be guarded against. Each case of this kind should be reported in detail. The writer refers to a case of Hodgkin's disease in which all of the superficial lymphatic glands and the spleen were markedly enlarged. Under prolonged *x*-ray treatment these were very much reduced in size, but whenever the exposures are discontinued for any length of time there is always a tendency for the recurrence of the manifestations. In the case of polycythemia there seems to be as yet no tendency toward a permanent reduction of the number of red cells to normal.—*The Archives of Physiological Therapy.*

A New Method of Treatment for Pulsating Exophthalmus.

Sattler (*Klin Monatsbl. f. Augenheilk.*, July, 1906). The author discusses the value of an operation on the orbit, consisting in ligature and resection of the aneurismally dilated superior ophthalmus. Ligature of the common carotid artery, while resulting in numerous and permanent cures, remains a rather dangerous procedure, which is sometimes followed by a fatal outcome. Moreover, the visual organ is exposed to a series of dangers, as a sequel to carotid ligature. The selection of the superior ophthalmic vein is recommended by the author on the basis of a very successful case, which was treated in this manner.—*Medical Review of Reviews.*

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THE ABDOMINAL REFLEX IN ENTERIC FEVER.

In the April number of *Brain*, 1906, Rolleston calls attention to this subject, and reports a series of cases in support of his observations. The author relates that Rosenbach was the first neurologist to call attention to this sign, but since that time it has been emphasized by Strumpell, Babinski, and van Gehuchten, and others in such organic conditions as hemiplegia, paraplegia, multiple sclerosis and tabes; he also takes into account the fact that some authorities claim it to be inconstant in health, but in opposition to such views are quoted the results of Muller and Seidelmann, who report 3,000 observations on individuals free from nervous or abdominal diseases, and in no case save one was this reflex found absent, and that one was questionable, the conclusion being that in a young person of either sex if thi reflex is found absent some pathological alteration is to be found. Jamin first drew attention to the loss or impairment of this reflex in the right side in acute conditions such as perityphlitis, gall-stone, colic, and cholecystitis, and in the more chronic conditions, such as ascites, tuberculosis, peritonitis, tumor, etc., an active response could often be obtained. Sicard in 1905 reported observations on this reflex in twenty-six children suffering from enteric fever, and other than this no previous report had been made.

For practical purposes the reflex is divided into two parts, the supra and the infra-umbilical zone. In enteric fever the infra-umbilical reflex is the first to be lost and the last to return, the supra-umbilical may remain active throughout this disease or, as is more commonly the case, a slight response rapidly exhausted after a few stimuli have been applied may be obtained in the epigastric region or sides of the abdomen alone when stimulation of the rest of the abdomen provokes no response. The author observes in his report sixty cases, all of whom were certified on admission to hospital to be suffering from enteric fever. During the acute stage observations were made daily. He then appends a series of tables, giving age and sex of patients, the relation of the abdominal reflex when first examined to the stage of the disease, also one showing the rela-

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tion of the abdominal reflex to the pyrexia, another in which is tabulated the date that the abdominal reflex became active, and lastly is given a table showing the relation of the abdominal reflex to the knee and ankle-jerks. Reference is then made to the method of eliciting this reflex, conditions required and errors to be avoided, and in conclusion the following summary is appended:

1. The abdominal reflex is affected in a very large number of cases of enteric fever, the percentage of cases in which it is entirely lost exceeding those in which its normal activity is diminished only.

2. From its absence under 50 being confined to certain nervous diseases and acute abdominal conditions, notably appendicitis and enteric fever, the absence of the abdominal reflex in a given case of continued pyrexia in any patient below fifty is of considerable diagnostic value.

3. The comparatively transient nature of the affection of the abdominal reflex in enteric fever is a striking contrast to the more chronic affection of the knee and ankle-jerks in diseases. associated with peripheral neuritis, *e. g.*, diphtheria.

4. Return of a lost reflex, and *a fortiori* resumption of its normal activity, are a valuable indication of commencing convalescence, and often correspond with lysis and characteristic changes in the feces and urine.

5. The objective sign of return of the reflex is often associated with the return of the subjective feeling of ticklishness normal to the individual.

6. In reappearance of pyrexia in convalescence, the condition of the abdominal reflex is a valuable index of the nature of the pyrexia.

7. No constant relation exists between the condition of the abdominal reflex and that of the tendon reflexes.

8. The frequency, degree and duration of impairment of the abdominal reflex are, as a rule, in direct proportion to the age of the patient.—*Western Medical Review.*

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OBSTETRICAL

The Effect of Quinine on the Uterine Contraction.

Differences of opinion have long existed among obstetricians in regard to the value of quinine as an oxytocic, and while some observers have lauded it as a useful uterine stimulant others have considered it either of no value for this purpose or at best unreliable in its action. A comprehensive summary of these conflicting views is presented in the *Deutsche medizinische Wochenschrift,* January 31, 1907, by Maurer, who also reports his own experiences with the drug. He administered it in sixty-three cases during labor and fifteen times in the treatment of abortion. In 78.2 per cent. of the cases he considers that an effect was produced which was the result of the medication and in the remaining 21.8 per cent it appeared to be without efficacy. His experience leads Maurer to believe that quinine undoubtedly strengthens the uterine contractions and perhaps may induce their onset, but that it shares with other oxytocics the disadvantages that its effects cannot be guaranteed in every case. According to Maurer's experience its administration is not attended by any untoward action on either the mother or child, and the uterine contractions evoked are physiological in character. In explaining its mode of action he assumes that, granted a normal uterine musculature, in cases of inadequate contractions there is a lessened susceptibility of the muscle to stimuli and the quinine serves to increase the irritability of the organ to the nervous impulses in question. It was found that the nature of the quinine preparation is of no importance and that it may be given either by mouth or hypodermatically. Maurer's routine method is to give one gram of the sulphate by mouth and if no effect is manifest at the expiration of an hour to give 0.5 gram more. If there is still no improvement in the conditions this dose is repeated in half an hour, but if this is ineffectual the patient is regarded as having an idiosyncrasy that renders her insusceptible to the influence of quinine.——*Medical Record.*

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Suspension of the Womb.

B. S. Talmey describes the method, which he has used for six years, of suspending the retroplaced uterus in women of child-bearing age. The abdominal incision of about 6 cm. is made in the linea alba, beginning immediately above the pubis; the recti muscles are separated, and the peritoneum is incised; the uterus is located and any adhesions are freed. The uterus is grasped at its posterior surface by a tenaculum and held in position. The round ligament is then located and is followed to the uterus. At this end the first suture of chromicized catgut is inserted and passed through the rectus muscle about 2 cm. from the abdominal incision and about 3 cm. above the symphysis. Another suture is inserted through the round ligament 1 cm. distally from the first, and in the same way it is passed through the rectus muscle. This procedure is repeated on the other side, and the sutures are all then tied and the abdomen is closed. After the operation a pessary is placed within the vagina, where it remains until the patient leaves her bed. The chief advantage of this method is that the operation is universally applicable and entirely satisfactory and the uterus is placed in the most physiological position.—*Medical Record.*

Comparative Advantages and Disadvantages of Hysterectomy and Removal of the Body of the Uterus.

Dr. J. Welsey Bovee, Washington, D. C., said that an important proportion of cases of tumors thought to be simple fibromata or myomata have in reality taken on malignant degeneration or are complicated by malignant degeneration of the corporeal endometrium. Carcinoma of the cervix has been detected within a few days after removal of the body of the uterus, showing clearly that it existed at the time of the supravaginal amputation. In some cases fibromata have existed for years, the patients declining operation, and cancer of the cervix developed subsequently, with fatal result. Bovee has seen two such cases. It has not been proved, he said, that cancer of the cervix occurs more frequently with uterine fibroids than without

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them. On the other hand statistical tables on the complications of fibroids demonstrate the remarkable increase in the frequency of cancer of the body of the uterus accompanying these growths. Even by the abdominal route complete extirpation of the uterus is not an operation that necessarily taxes the patient's vitality to an extent appreciably greater than removal of the body alone. Objections to the removal of the cervix with the body because of weakening of the vaginal roof and shortening the vagina are practically nullified by suturing the round and broad ligaments to the vaginal walls. The comparative ease of the amputation is of moment only in critical cases. The cosmetic effect to young women deserves more consideration. Often retention of the portio vaginalis is deemed by them to be of great value. In a young woman without a family history of malignant disease and in the absence of uterine growths the cervix should not be removed if the body is to be removed by the abdominal route. In very critical cases in which the body of the uterus is to be removed, even in the presence of tumors, it will occasionally be advisable not to remove the cervix. In practically all other cases the cervix should not be saved, especially in old women, particularly if evidence of uterine growths be present.—*The Journal of A. M. A.*

Puerperal Insanity.

Puerperal insanity is typically an acute mania; any one of the so-called causes of insanity, for example, fright, shock, undue worry, or a neurotic inheritance will render the patient liable to an attack. The writer does not think that the thesis that sepsis is invariably present can be sustained, though a considerable proportion are undoubtedly septic. The prognosis is favorable, and with a good family history, and in the absence of septic poisoning, recovery may be anticipated within six months, and subsequent attacks are not greatly to be feared.

Special symptoms must be dealt with as they arise, but the essence of treatment consists in an abundance of bland nutritious food and competent nursing.—*Alan Rigden* (*British Medical Journal*, November 10, 1906).

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages, at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

A PLEA FOR HUMANITY.

To the Governors of the several States, the Members of Congress representing the different Congressional Districts, the State Senators and Members of the Houses of Representatives, the Mayors of the different Cities, and the Editors of the United States:

For some years past the question has been agitated by physicians, philanthropists and others as to what means should be employed to stamp out the "great white plague," consumption, which is destroying 150,000 people annually in the United States.

The concensus of opinion of specialists and experts, who have studied this disease is that sanitorium treatment under proper medical restrictions and the segregation of these patients, is the proper means to accomplish this end.

In order to do this private sanitoriums have been established in different parts of the Union by different individuals. Some states have taken action in the matter and are preparing to care for their indigent consumptives.

Now, in order to reach the people in those states where no action has been taken the American Anti-Tuberculosis League has formulated a bill to be presented to each Legislature at the next session of the same, providing for the establishment of a state sanitorium to take care of those who are unable to pay their expenses in private sanitoriums. In order to create sentiment and assist in this work, we are asking the different states to lend us their assistance in order to organize a sentiment which will insure the passage of this or similar bills.

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The Governor of each state has been invited to be present at this meeting, and to appoint as many delegates (preferably physicians) as he may see fit, to meet with this League at Atlantic City, June 1st to 4th, 1907, in order that definite plans may be arranged for carrying out the business of this League.

The Congressmen of the United States have each been requested to appoint as many physician delegates as they desire from their districts, and each of them have been invited to be present at the meeting.

The Mayors of the different cities of the Union have been requested to appoint a number of physician delegates to represent their cities at this meeting and to attend in person.

To the editors of the United States we respectfully submit the following: It is absolutely in their hands to secure the passage of each of these bills if they will give us their moral support in this work. In order to help us we request each editor who receives a copy of this circular to give space to it in his paper, and if he feels disposed to assist us, to write a leading editorial on the subject and to forward a marked copy of the paper containing the same to the undersigned.

We cordially extend to each editor in the United States an invitation to be present at this meeting, or to have a representative of his paper in attendance. Every courtesy will be shown them, and it is our earnest desire to enlist their co-operation and assistance in this great work. We fully realize what they can do and the amount of assistance they can lend to suffering humanity, if we can secure their aid and co-operation in our humanitarian undertaking.

At the last meeting of the League, which was held in Atlanta, Ga., we had enrolled over 3000 physicians, who had taken an interest in this work and assured us of their co-operation. We expect a great many more than this to be with us at Atlantic City, and we earnestly call upon all people who are interested in this work to communicate either with the members of the League in their State, or to the executive office and give us their moral support and co-operation in assisting these people who are unable to take care of themselves.

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With many thanks to those who have kindly assisted in the work, and trusting I may have the honor to meet a great many of those invited at the next meeting, I am, Very respectfully,

GEORGE BBOWN, M. D.
President and Executive Officer.

Atlanta, Ga., U. S. A.

ANNOUNCEMENT.

The *Journal of Inebriety,* after thirty years of continuous studies of the disease of inebriety and drug taking, begins its new decade by entering upon comparatively new field of physiological and psychological therapeutics, for the treatment of these neuroses. Arrangements have been completed by which the *Archives of Physiological Therapy* has been consolidated and will hereafter be published as a part of the*Journal of Inebriety.* This very able monthly has been developing parallel lines of study with the *Journal of Inebriety.* In the opinion of its managers its scientific value would be greatly enlarged by concentrating its work along some special lines. The disease of inebriety and its allied neuroses is a field of most practical interest, hence the *Journal of Inebriety* is selected as a medium for continuing the work of the *Archives of Physiological Therapy.*

Henceforth in addition to the various diseases of this subject which the *Journal* has presented, the therapeutic effects of hot air, radiant light baths, electricity, massage, psycho-therapeutic measures and other physiological means will occupy a prominent space. This effort to clear away the confusion and broaden the studies of therapeutic means for cure, will make the *Journal of Inebriety* one of the most practical and valuable visitors to every hospital and institution, as well as all specialists who treat brain and nerve neurotics. We shall aim to present and formulate the latest studies, and facts along these frontier lines, and in this way lift the whole field of therapeutics out of its present emperic stage into one of rational therapeutics.

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To the Editor:

I take the liberty of sending you a statement of the requirements for admission to the Medical Department of the University of Pennsylvania, which have recently been adopted by the Board of Trustees.

According to the plan finally adopted, the requirements will be increased gradually beginning with the annual session in September, 1908, and reach the maximum September 1910. The present requirements cover four years graded course in a High School or its equivalent. The essential points in the new

I. For the session of 1908-1909, in addition to the present requirements, either one of two foreign languages, French or German; (2) Physics; (3) Inorganic Chemistry, including qualitative analysis; (4) General Biology or General Zoology.

II. For the session 1909-1910, in addition to the requirements of 1907-1908, the candidate must have completed successfully work equivalent to that prescribed for the Freshman Class in Colleges recognized by this University.

III. For the session 1910-1911, in addition to the requirements of 1907-1908, candidates must have completed successfully work equivalent to that prescribed for the Freshman and Sophomore Classes.

IV. Candidates who have successfully completed at least three years of an accepted College Course, may be admitted with conditions in Chemistry, Physics and General Biology or Zoology.

The maximum requirement is two years of collegiate training, including Biology, Chemistry and Physics. The two additional years of collegiate training are regarded as an adequate preparation for entrance into a professional school. The importance of the candidate having had instruction in subjects leading to the study of Medicine is so generally recognized that Biology, Chemistry and Physics have been added to the requirements. This combination of special and general training is without doubt a much more logical requirement than a Collegiate degree which does not imply any special preparation for medical studies.

Yours truly,

CHARLES H. FRAZIER.

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New York Skin and Cancer Hospital.

Second Avenue, Cor. 19th Street.

The Governors of the New York Skin and Cancer Hospital announce that Dr. L. Duncan Bulkley will close his clinical course with four special lectures:

March 27.—Practical points in the diagnosis and treatment of diseases of the skin.

April 3.—Errors in diagnosis and treatment; don'ts in dermatology.

April 17.—The significance and treatment of itching.

This also announces a lecture by Dr. William Seaman Bainbridge:

April 24.—Some phases of the cancer problem.—Illustrated by a series of cases.

They will take place in the Out-Patient Hall of the Hospital, at 4:15 o'clock. The lectures will be free to the medical profession.

William C. Witter,
Chairman of Executive Committee.

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Reviews and Book Notices

An Epitome of Diseases of the Nose and Throat.—B. J. B. Ferguson, M. D., of the New York Post-Graduate Medical School. 12 mo, 243 pages, with 114 engravings. Cloth, $1, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1907. (*Lea's Series of Medical Epitomes.* Edited by Victor C. Pedersen, M. D., New York.)

A very useful contribution to this important branch of medicine. This number of the Medical Epitome Series will be exceedingly helpful to the student and post-graduate student in gaining familiarity with laryngological work. In systematic arrangement, in its clear direction of examinations and in its accurate illustrations it ranks well with preceding numbers of this important series. We recommend it to students and practitioners interested in this field, as a good working hand-book.

Thornton's Pocket Medical Formulary.—New (8th) edition, revised to accord with the new U. S. Pharmacopœa. Containing about 2,000 prescriptions with indications for their use. In one leather bound volume. Price, $1.50, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1907.

The widespread popularity of this pocket *vade-mecum* is amply attested by its appearance in its 8th edition. Its usefulness as a help to the physician in selecting formulas for use in practice is unquestionable, and a feature that enhances its value in a marked manner is found in the indications for a choice. It has been carefully revised to make it accord with the New United States Pharmacopœia. It is an excellent arrangement and well selected collection of formulas.

The New Hygiene.—Three Lectures on the Prevention of Infectious Diseases.—By Elie Metchinkoff (author of "The Nature of Man.") With preface by E. Ray Lankester. W. T. Keener & Co., 90 Wabash Avenue, Chicago, 1906.

The name of the author of this collection of lectures is sufficient guarantee of the scientific nature of the matter presented. The book contains three lectures, intended mainly for the lay reader, but notwithstanding, as well, to the medical man on the

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following subjects. 1. The Hygiene of the Tissues. 2. The Hygiene of the Elementary Organ. 3. Hygienic measures against Syphilis. The investigations and discoveries of Metchnikoff in collecting pathology should make the book valuable to the profession.

Text-Book of Psychiatry—A Psychological Study of Insanity for Practitioners and Students.—By Dr. E. Mendel, A. O. Professor in the University of Berlin. Authorized Translation. Edited and enlarged by William C. Krauss, M. D., Buffalo, N. Y., President Board of Managers Buffalo State Hospital for Insane; Medical Superintendent Providence Retreat for Insane; Neurologist to Buffalo General, Erie County, German, Emergency Hospital, etc.; Member of the American Neurological Association. 311 pages. Crown octavo. Extra cloth. $2 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This is a translation of a well known work and has been prepared especially to meet the needs of medical students. The abstract nature of the conditions the work aims to elucidate, the every-day nature of the complaints treated of and the clearness with which the subject is presented will make the work readily take rank with other well known treatises upon the subject.

Heaven and Hell, also the World of Spirit of Intermediate State from Things Heard and Seen.—By Emanuel Swedenborg, originally published in 1758. Rotch revision, Swedenborg Printing Bureau, 16 Arlington street, Boston.

This is an expression of the beliefs of Emanuel Swedenborg, as given by him one hundred and fifty years ago. It should furnish interesting reading to all interested in religious systems.

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Publisher's Department

Sanmetto in Enlarged Prostate and Chronic Cystitis, Irritable Bladder and Urethra.

I have used Sanmetto in enlarged prostate and chronic cystitis in old man, with marked good results, and observed that there was decided aphrodisiac effects; also in irritable bladder and urethra in the early months of pregnancy, with very happy results. M. A. Rush, M. D.

Anderson, Ind.

Thomas W. Forshee, M. D., of Madison, Ind., writing says:

"It is a pleasure to me to add my testimony to the hundreds of other physicians in attecting the merits of Sanmetto. I have used it extensively in my practice since its inception, and without any failures where it was typical. For vestical irritation in both male and female, I nd it perfect. Not that every case is cured by it; but when I make failures I find them due to some mechanical displacement, or to tuberculosis conditions. For prostatitis I have never found any remedy that approximated it. I have used it myself with remarkable success. It is not necessary for me to say that I shall continue its use where indicated."

Things Good and Bad.

Dr. Uriel S. Boone, formerly Professor of Pharmacology and Surgery, College of Physicians and Surgeons, St. Louis, says:— "There is *one thing bad* about the grippe. Its victims instead of being rendered immune by the first attack, seem to become more liable to its recurrence. There is one disconcerting feature about it. Its symptoms resemble those of so many far more serious maladies. This country is full of people who are going about darkly ruminating, because of evidences of heart trobule, nervous prospration, dyspepsia, liver complaint and old age, "together with a plentiful lack of wit and weak hams."

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"There is *one thing* good about the grippe. It yields rather readily to the "antikamnia and quinine tablet" treatment. This remedy given in one or two tablet doses, every three hours, with plenty of rest in bed, and among pleasant and quiet surroundings, will work wonders.

"If suffering from nervous headache, nervous exhaustion, general nervousness, muscular aches, irritability or insomnia, administer one "antikamnia and quinine tablet" three or four times a day at regular intervals. Nothing equals this remedy in relieving the organic pains of women, and this without unpleasant after-effect. In these particular cases, prescribe one tablet every hour until three are taken."

From time to time new coal-tar products are introduced, and very often these disappear within a few months after they have been brought to the notice of the profession, simply because they do not prove a special value or else have been found to exhibit dangerous properties. Not so with Phenalgin, which is a product put upon the market by the Etna Chemical Company, New Yory (London agent: Mr. E. J. Reid, Basinghall Avenue, E. C.). Phenalgin is ammonio-phenylacetamide. Like products of a somewhat similar composition it possesses three distinct properties. It is an analgesic. In this respect it bids fair to rival completely phenacetin, and is of special service in cases of neuralgia and headaches of various kinds. In dysmenorrhœa it is likewise of great service, small repeated doses frequently acting as a charm in relieving this distressing complaint. Then again it is useful in reducing temperature. Here it find a useful application in the hectic fever of tuberculosis, small doses being gives with marked benefit in such cases. In fact Phenalgin is one of the best all-round antipyretic agents known, and is more reliable than any other product of similar origin. Lastly, it acts as an hypnotic, partly by relieving pain and partly by allaying nervous restlessness, so often met with in diseases of various kinds.

The product is chemically pure, and is put up in pink-top capsules and in tablets. These capsules are made of the best gelatine and are absolutely free from all impurities, retaining their

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strength, it is said, for an indefinite period. The tablets contain two and one-half grains of phenalgin, and the capsules five grains each of the powder. The dose ranges from 2½ to 10 grains, repeat in half-an-hour if necessary. In cases of dysmenorrhœa ten grains should be taken every half-hour until relieved. At least these are the directions given by the manufacturers, but probably much smaller doses will be found sufficient. From personal trial of Phenalgin we can strongly recommend it as a valuable substitute for phenacetin. Its great advantage is that it is not known to the public, whereas phenacetin is, and apart from this it is a distinctly pure product from which good results may always be confidently expected. Samples and further particulars can be had for the asking at any time from the London agent, who will also answer any inquiries relating to this new remedy. We strongly advise our readers to give it a trial in their practice.—*Medical Times,* London, England.

"The experiments of Drs. Charteris and Latham prove that the presence of ortho and para-cresotic acids as impurities in artificial salicylic acid causes intense gastric irritation and depression of the heart; furthermore, since artificial salicylic acid and its derivatives are eliminated in the urine they are destructive to the kidneys and should therefore never be employed for internal administration.

None of these objections apply to salicylic acid from natural sources or to its derivatives."

Attention is called to the fact that all the salicylic acid in the Tongaline Preparations is made by the Mellier Drug Company from natural sources.

The Phosphates of Iron, Soda, Lime and Potash, dissolved in an excess of Phosphoric Acid, is a valuable combination to prescribe in Nervous Erhaustion, General Debility, etc. Robinson's Phosphoric Elixir is an elegant solution of these chemicals. (See page ——.)

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SAMUEL S. BRIGGS, M. D., Associate Editor

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Original Communications

DIPTHERIA.

BY J. B. MURFREE, M. D. MURFREESBORO, TENN.

Diptheria is an acute febrile infectious and a contagious disease, characterized by local manifestations and decided constitutional symptoms. The local manifestations consist in morbid lesions, in the throat and air passages, while the constitutional symptoms manifest themselves by an increased bodily temperature, a rapid, weak pulse, and great depression of the nerve centres, albuminuria and a tendency to death from toxemia, asphyxiation and heart failure.

The disease prevails both sporadically and epidemically and is caused by a germ, a micro-organism, called the Klebs-Loeffler bacillus, the bacillus diptheriæ, which produces a croupous inflammation upon mucous membranes and also upon abraided, cutaneous surfaces. It is one of the most dreaded, one of the most fatal, as well as one of the most common diseases of childhood.

At the beginning it is impossible to say whether the disease will be mild or malignant. Diptheria, at the beginning of infection is a local disease, but as the bacilli multiply, they produce certain poisonous substances, called toxins, which enter the circulation and lymph channels, and produce the constitutional symptoms.

*Read before the Middle Tennessee Medical Association, at McMinnville, Tenn., May 17, 1906.

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Rarely, are the bacilli ever found in the blood; it is their toxins that produce the grave constitutional conditions. Diptheria especially attacks children, rarely adults; it is eminently a child's disease, statistics showing that more than eighty per cent. of cases occur in children under fifteen years of age. Very rarely indeed, it attacks the new-born. Nursing children are very seldom attacked, while the largest number of cases occur in the second to the sixth year. It prevails among all classes, all races, and in all parts of the world, and at all seasons of the year, but more often in the winter and spring. It is both contagious and infectious—it is contagious from person to person by direct contact and may be carried in this way to distant parts by clothing, books, toys, etc. It is infectious to a very limited extent. The period of incubation is short but not definite—two to eight days—three days being the average.

The specific and essential cause of diptheria is a germ, the bacillus diptheriæ, which was discovered by Klebs in 1883, and independently by Loeffler in 1884, in the secretions from mucous membranes of individuals affected with diptheria. The Klebs-Loeffler bacillus is found in nearly all cases of true diptheria. It is a very minute germ in the shape of a rod, non-motile and very tenacious of life, it is destroyed by exposure to heat for ten minutes at a temperature of one hundred and thirty six degrees; it is not destroyed by cold. It adheres to articles of clothing and bedding, also to some of the domestic animals, as cats, dogs and birds, and by these, may be carried to long distances and there develop the disease.

While the Klebs-Loeffler bacillus is the direct cause of diptheria, yet it is often found associated with other micro-organisms, especially the streptococcus and the staphylococcus, and then we are likely to have a mixed infection. The bacillus diptheriæ has been found in the throats of healthy individuals, without the disease being produced in them, but may be conveyed to others.

Experiments have demonstrated that the Klebs-Loeffler bacillus, like most other germs, forms toxins, or poisonous substances. which are very positive in their action. While the bacillus enters

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the mucous membrane of the throat, and there causes an exudation which forms the pseudo-membrane, which is characteristic of croup.

They do not generally enter the circulation themselves, but their toxins are carried into the general system through the blood vessels and the lymph channels, and by their poisonous action give rise to the constitutional symptoms of diptheria and the wide-spread effects of this disease. These toxins injected into the lower animals that are susceptible, produce all of the characteristic lesions of diptheria, except the membrane. For the production of the membrane, living bacilli are necessary; the bacilli alone do not produce any constitutional effect, and on the other hand, the toxins do not produce the pseudo-membranes. The formation of the pseudo-membrane in the throat is not the essential morbid lesion in diptheria, but the wide-spread effect of the toxins in producing degenerative changes in the cells of the body.

In post-mortem examinations the membrane appears as a fixed brownish or grayish mass—it may be soft and pliable or tough, like cartilage. Sometimes it appears as a white pellicle and again it may be almost black. Usually, it covers both tonsils and may extend over the pharynx nares and larynx, while the surrounding surfaces are deeply injected. The Klebs-Loeffler bacillus is found multiplying in the gangrenous mass, and in the exudation, but not in the living tissues.

The heart, the lungs, the spleen, the liver, the kidneys, the lymph nodes, the nerves, the stomach, the middle ear and the blood have all shown evidences of pathological changes. The membrane itself is simply the result of the croupous inflammation and sometimes occurs without the presence of the bacillus. The symptoms of diptheria are usually well marked, the pseudo-membrane being the characteristic feature. Yet it is sometimes difficult to distinguish it from other inflammations of the throat when accompanied by a membranous formation, aye, in some cases it is impossible to distinguish between a true and a false diptheria, except by a bacteriological examination.

The presence of the Klebbs-Loeffler bacillus is the only positive

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test of diptheria. In diptheria generally, there are no prodromal symptoms, but the outset of the disease is sudden; rarely does it begin as a latent disease. Occasionally, however, we meet with a child who is listless, has a slight fever with headache, loss of appetite, yet without any membranous formation in the throat, yet in 24 to 48 hours evidence symptoms of diptheria will be manifest. As a rule, the onset of the disease is sudden.

In young children, there may be a slight convulsion at the onset of the disease, but this is unusual. In the beginning, there are sensations of chilliness, with some increase of temperature, and more or less pain in the head and back, with a sore throat. The child complains of pain in swallowing and is indisposed to nurse or to take food. At first the throat will be found to be red and inflamed, but later on, a white, or grayish white membrane is seen, first on the tonsils, which soon extends to the palate, uvula, and perhaps to the pharynx.

As the disease advances the throat becomes much swollen and the tonsils so much enlarged, as to almost meet in the centre; the whole surface being covered with the diptheritic membrane, which is firmly adherent. The membrane assumes a brownish or gray yellowish color, often becoming gangrenous, with an excessive fetid odor. In severe cases a profuse nasal discharge takes place and if the patient is septic, spots of ecchymosis appear on different parts of the body, indicating a grave systemic infection, usually significant of a fatal issue. The patient is listless, but not delirious. Active delirium is uncommon in diptheria.

Later on in the disease an eruption like that of scarlet fever may appear. The cervical glands become considerably swollen and painful, while the child shows grave constitutional symptoms. In diptheria, the temperature is not characteristic. Usually it ranges from 101 to 102, in some cases 104 to 105. A subnormal temperature is of more serious import than a moderately high one. The pulse is the better index to the child's condition than the temperature. The pulse is rapid and weak; the weakness being in proportion to the severity of the disease and does not correspond with the temperature. Sometimes it is very slow, as the result of the action of the toxin on the nervous centres and

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the weakness of the heart. Diarrhœa frequently occurs, but is not constant while loss of appetite, nausea and vomiting are the usual accompaniments.

In mild cases, the symptoms abate towards the end of the first week, the fever subsides, the membrane disappears from the throat, the swelling of the cervical glands decrease and the child feels better, but is left in a weakened and enfeebled condition. Even in mild cases the poisonous effects of the disease may produce a natural ending in paralysis and sometimes, after the disease has subsided, a discharge from the nose continues, due to an inflammation of the posterior nares. Cardiac weakness is apt to be a prominent symptom in all cases of diptheria, and occasionally the child dies suddenly without any warning. The disease varies greatly, both in the severity of the constitutional symptoms and the local lesions.

The virulence of the bacteria is much greater in some epidemics than in others, and even in the same epidemic, there is a variation in its virulence. There are three factors which are supposed to determine the severity of the cases:

1. The virulence of the bacillus.
2. The local resistance.
3. The general resistance.

Diptheria in the malignant form is one of the most frightful, as well as the most unmanageable diseases that I have ever met with. In these malignant forms we have either a seemingly mild attack of the disease for a few days, when suddenly it developes the severest symptoms, or the malignancy may be evident at the outset.

In these cases there is a rise of the temperature with increased weakness and rapidity of the pulse. The pharynx, tonsils and uvula are covered with a dirty, brownish membrane, there is an ichorous discharge from the nose, perhaps a profuse bleeding.

The tonsils, uvula, pharynx, cervical glands become necrotic, the membrane is thrown off in pieces while the breath of the child is exceedingly offensive. There is great prostration, and now the membrane may extend into the larynx, trachea and lungs.

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The pulse is so weak that it can scarcely be felt, and so rapid that it cannot be counted, while the temperature is but little raised, or perhaps may be sub-normal. A Bright's disease is developed, and in some cases there are hemorrhages under the skin, from the nose, mouth, throat, bowels, and even from the kidneys. Of these cases only a few ever recover, and then it is usually with some permanent defect.

In laryngeal diptheria there is an extension of the membrane into the larynx and the invasion is ushered in by a croupy cough and stridulous breath. The cough is persistent and harassing, while the stridor increases to such an extent as to be audible over the room. The breathing becomes more labored and gives the impression of a mechanical obstruction in the larynx. In these cases of increasing obstruction, the child's face assumes an anxious expression, he can only speak in a whisper, the lips are cyanosed and the surface cool, and if the obstruction is not relieved by a coughing up of the membrane, or surgical interference, death soon closes the horrible scene.

The diagnosis of diptheria during an epidemic is not difficult, but in sporadic cases it is sometimes extremely difficult, the case is diagnosed by the observing of the characteristic membranes in the throat—its color, appearance, situation and tendency to spread, together with the constitutional symptoms usually present in diptheria. Clinically, we cannot always diagnose diptheria, and in doubtful cases must rely on the microscope. Diptheria never arises *de novo,* but is always caused by the bacillus diptheria and in no other way can it be produced.

The treatment of diptheria is prophylactic, constitutional and local. The prophylactic treatment consists in scrupulously isolating the patient and thoroughly destroying or disinfecting all secretions, exudations, etc., that are discharged from the parts affected, while the room—the furniture, bedding, etc.—must be rigidly and repeatedly disinfected. Perfect cleanliness and thorough disinfection is the watch-word and the reply in the prophylactic of diptheria.

The constitutional treatment of diptheria consists in the early adminisration of the anti-toxin; its place in the therapy of diptheria

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is now assured, and as soon as diptheria is diagnosed, the anti-toxin should be administered at once and repeated at regular intervals until the disease begins to subside. The anti-toxin is the one remedy above all others in the treatment of diptheria, and to secure its full value, it should be given early in full doses and repeated at regular intervals. In a suspected case, do not wait for a culture test, but give the anti-toxin at once, for if the disease is not bacillary diptheria, no harm is done.

In addition to the anti-toxin, the general management of the patient must be looked after—rest, quietude, free ventilation, good feeding, with proper stimulation, must all be carried out. If the temperature should be high, it should be reduced by cold sponges, but never by anti-pyretics nor heart sedatives. For the heart weakness, alcohol, digitallis, strychnine, nitroglycerine; for respiratory weakness, atropin.

Whiskey or brandy should be given in full doses from the beginning to the end of the disease.

The local treatment consists in the cleansing and disinfecting of the throat, nose and pharynx, by irrigation, spraying, or local applications. In laryngeal diptheria when the obstruction is increasing, threatening suffocation, the child should be intubated, and if this fails, a tracheotomy must be done.

Biography—Thompson's Practice. Rotch, Pediatrica. Rurah Diseases of Children. Holt, Diseases of Infancy and Childhood. Fruwald and Wescott, Diseases of Children. Starr, Disease of Children. Kopin, Diseases of Infancy and Children.

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OBSTETRICS.

BY E. S. MCKEE, M. D., CINCINNATI.

Colpeurynter or Knife?—A case of puerperal inversion of the uterus by Dr. F. V. Neugebauser (Zent. f Gynak). The writer, during twenty years, has met but five cases of inversion of the uterus, and all of puerperal origin, in an experience covering 52,000 patients.

The present report concerns a primipara, 19 years old, who, three months previously had been delivered spontaneously. The placenta was delivered by traction on the cord by the attending midwife and the patient became unconscious. A physician revived her without making a local examination. Two weeks later a second physician discovered a "tumor." Patient reached the hospital very anemic and weak. A diagnosis of inversion with edema of the uterus was readily made. Two months trial of the colpeurynter bags was made without benefit, and operation was decided on.

After making a horizontal incision in the posterior vaginal vault the index finger was pushed into the funnel made by the inverted uterus. A knife passed along the finger, cut the posterior uterine wall a distance of 4 to 5 cm. in a direction toward the fundus. The uterus was easily reduced, the edges of the uterine wound pared and sutures introduced. The uterus was anteflexed and the vaginal incision closed. The patient was cured.

A Case of Ectopic Gestation at Full Term.—Dr. R. Mond (Zent, f Gynak). The patient was a multipara thirty years old, who considered herself in a condition of normal pregnancy. Fetal movements ceased and the woman experienced chills and fever which went on for months. A laparotomy was done, the extensive adhesions separated, and the entire products of conception removed. The placenta was removed piecemeal and vaginal drainage instituted. Recovery was smooth.

Superstition in Teratology.—The belief in maternal impressions affecting the fetus is vigorously attacked by E. T. Shelly,

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Atchison, Kan. (*Jour. A. M. A.* Jan. 26). While the ancient notions regarding monstrous births, which he mentions have been given up by modern authorities, he quotes from a number of recent text-books showing that the belief in maternal impressions is by no means entirely abandoned. It has, however, he says, only one argument in its support, that is, that of *post hoc ergo propter hoc.* Against this, we have the scientific fact that the relation of the fetus to the mother is not one of continuity, but simply of contiguity, the mother being the host and nourisher of the developing child. The physiologic relationship between the mother and embryo is so slight that for the practical difficulties involved, the impregnated human ovum might be transferred from one womb to another without interrupting its development, as has actually been done in some of the lower animals. Even the blood of the mother can only reach the child by osmosis through a membranous barrier, and there is no direct nervous communication whatever. The unfortunate structural aberrations originate very early in development and often before a woman is aware of her condition, and practically always before the maternal impression, to which the anomally is ascribed, takes place. The real objection to the superstition, however, is the baneful effect on the expectant mother, to say nothing of the bad effect it has on the study of teratology, cases which should receive careful scientific study being relegated to idle speculation on maternal impressions and fancied resemblances.

Report of a Case of Encephalo-Cysto-Meningocele-Operation.—Fred J. Taussig (*Med. Fortnightly*). A meningocele was discovered protruding through an opening in the cranium hardly larger than the end of one's thumb, as the head was bulging the perineum.

Six hours after delivery a beginning necrosis was noticed at the top of the mass and an operation was determined on. This meningeal sac was cut away and within this sac was found a small piece of brain tissue which was ligated and cut away. The skin was closed with interrupted silk-worm gut. The child passed a good night and on the following day there was a possibility of its surviving.

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A Report of Two Cases of Puerperal Septicaemia Complicated by Abscess of the Parotid.. A B. Davis (*Bull. of the New York Lying-in Hospital.*) Both of these cases suffered from septicæmia and a considerable time after their delivery each developed an inflammation in the right parotid gland, which grew and spread rapidly, and then in a short time subsided, except in the gland itself and its very near surroundings. Here it remained for a number of days as a tense, painful, brawny swelling, in which it was impossible to make out softening or fluctuation; or to know in which direction to cut in order to give relief. Both patients had pneumonia. One seemed to have a profound streptococci infection. Her resistance had been lowered by an acute anæmia from hemorrhage and the shock of operative delivery. She was profoundly septic within a few hours of the delivery of her child, and continued to be so, with an increasing anæmia until her death. The other patient, while at times she seemed equally ill, would respond in some measure to treatment. No bacterial growth could be found in her blood or in the discharges, but staphylococci were found in the pus from the parotid abscess. She had the anæmia always found in septicæmia, but as her septic processes began to subside the quality of her blood improved. Stress is laid on the open air treatment in such cases, keeping the bed on the roof exposed to the sun and air in all but stormy days.

Puerperal Eclampsia.—Dr. J. B. Halligan gives the following treatment during the attack. He says that this depends on the condition of the patient, and whether delivery is near or remote or has taken place. The author believes that the presence of repeated convulsions at any period of pregnancy is an indication for termination of pregnancy, as it is a well established clinical fact that the convulsions often cease upon the death of the fetus or upon the delivery of the child. The presence of convulsions at an early period of pregnancy indicates an extreme virulence of the poison or an undue susceptibility of the patient, either of which would most likely prevent the carrying of the child to term. Morphine is, in the author's opinion, the most reliable simple remedy in the treatment of eclampsia. It can be given hypodermically at the same time that chloral is given by the rectum.

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Thirty grains of chloral in one quart of normal salt solution is given per rectum as indicated. Morphine obtunds the sensibility of the nervous system, making it less susceptible to the irritating action of the toxic material in the blood. The use of salt solution dilutes the blood and is therefore less irritating to the nervous system. It also powerfully increases the renal secretions acting as an eliminant. In this respect it antagonizes the action of morphine, which has a tendency to suppress renal secretion. Calomel and croton oil are clearly indicated in nearly every case. Chloroform controls the convulsions for the time being. The patient should be wrapped in hot blankets, which should be changed every half hour. Veratrum viride has its advocates, but the author does not believe its employment rests on a rational basis. It is one of the most dangerous depressants in the materia medica. It also increases the mucus secretion, thereby directly increasing the danger of deglutition pneumonia .

Does Malaria Pass from Mother to Fetus?—Drs. N. Pepozoulos and J. Cardamatis (Grece medicale). Formerly this question was unhesitatingly answered in the affirmative. Since the discovery of the malaria plasmodia, however, it has again become doubtful. Both of the Greek professors examined most thoroughly six new-born of malarial mothers, but found no trace of plasmodia. The blood of the placenta on the maternal side contained numerous plasmodia, but on the fetal side none were found. The same results were obtained also in the umbilical cord. The authors were thus able to confirm the statements of Bignami and Sereni to the effect that malarial affection of the mother exerts no influence upon the development of the fetus.

Diphtheria of the Puerperal Uterus.—Dr. M. P. Orband (Allg. Wien. Med. Ztg.). The patient was 21 years old, a ii-para, and entered the hospital with the arm of the child protruding from the vulva, since four days. Decapitation was followed by extraction of the child, and the vagina was douched with sublimate solution. After the second day the patient developed fever of a low grade with some pulse acceleration and restlessness. On the fifth day a thick whitish deposit was discovered on the labia and in the cervical and uterine canals accessible to inspection. A num-

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ber of fragments of this tissue was obtained with the curette and the parts thickly dusted with iodoform. On the sixth day anti-streptococcus serum was injected in the gluteal region, which was repeated several times. The nose and throat were free from patches. On the ninth day 2,000 units of anti-diptheritic serum were injected and repeated on the next day. She was cured on the 15th day. The bacteriological examination of the specimens of membrane showed the presence of large numbers of diphtheria bacilli mixed with streptococci and staphylococci. The case is regarded as one of primary diphtheria of the puerperal uterus.

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Selected Articles

Management of Pregnancy, Labor and the Puerperium.

JOHN C. MURPHY, M. D., PROFESSOR OF OBSTETRICS, ST. LOUIS COLLEGE OF PHYSICIANS AND SURGEONS.

Many do not attach the importance to obstetric practice that they should, thinking that their whole duty is done if they conduct the patient through labor without a funeral. As a matter of fact the three stages constitute a trinity, being indissolubly linked together, and the physician must see to it that one glides placidly into the other without jar or friction. And how is this happy result to be realized? Only by watchfulness and care from beginning to end. Some obstetricians (?) look after the temporal welfare of their patients like they attend to the spiritual welfare of their own souls, i. e., time enough to worry later on. A little attention in advance in either case may save greater worry later. The obstetrican's duty starts at the beginning of pregnancy, and continues until the end of the purperium and the patient has been restored to as normal a condition as existed prior to pregnancy. No man has less excuse for surprise than the accoucheur, as he has had ample time in which to prepare for possible emergencies. Now what are his duties in each respective period.

Pregnancy.

First obtain the history of the patient as to previous labors, miscarriages, etc., ascertain the existence of any constitutional disease, as tuberculosis, syphilis or organic heart disease. Any existing disease may have an unfavorable influence on pregnancy and cause premature expulsion of the ovum and death of the mother. Syphilis, for instance, is said to be responsible for about 70 per cent of all abortions. In the presence of maternal syphilis, if recognized early in pregnancy, and vigorously treated, we may prevent loss of the ovum. Every pregnant woman should have a careful physical examination, including the heart, lungs, kidneys,

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abdominal viscera and pelvic organs. Any abnormality of the thryoid gland should be noted, as goitre in some form is not infrequently present, and may produce alarming symptoms from pressure due to increased growth. Goitre also predisposes to post-partum hemorrhage. The heart should be given particular attention; a valvular lesion may exist with little or no symptoms other than those detected by ausculation and percussion. Dyspnea, if present, may be mistaken for that caused by pressure of the gravid uterus. The increased work thrown upon crippled heart by pregnancy may cause a break in the compensation, and death from acute dilatation, endocarditis pulmonary edema, etc. This calamity may be averted if we take the trouble to find out in time and apply proper treatment, as regulation of diet, increasing elimination by the bowels, kidneys and skin, and the securing of mental and physical repose. Osler mentions numerous cases where a break in the compensation has been restored without the use of heart tonics by simply keeping the patient quietly in bed for a week or two. In any event proper advice may obviate the necessity for more active measures.

The urine should be examined, at least once in two weeks from the third month of pregnancy to the close. In examining the urine the total quantity passed in the previous twenty-four hours should be noted, the specific gravity taken and the specimen tested for albumen and sugar. In suspicious cases a microscopic test should be made for casts and renal epithelium. A diminished quantity of urine with low specific gravity, indicates renal insufficiency with the retention of toxins in the blood, which may terminate in uremia and death or eclampsia during labor. If the microscope reveals tube casts and renal epithelium in quantity it means nephritis. Albumen alone does not always mean structural change in the kidneys, as about six per cent of all pregnant women have albuminuria, it does mean that the kidneys are functionally deranged from pressure of the gravid uterus on the kidneys, or ureters, or congested from impeded circulation. The kidney in this condition is termed the "kidney of pregnancy," a condition which undoubtedly predisposes to eclampsia. These complications may be modified or averted by proper treatment. The use

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of diuretic mineral waters, restriction of the diet, saline catharsis, warm bathing, etc., will do much towards minimizing such troubles and saving life.

The pelvic organs must now be examined, the uterine appendages must be recognized and their condition ascertained. Tubal pregnancy and intrauterine pregnancy may be indistinguishable until rupture of the tube. The size and position of the uterus should now be determined. If the fundus is felt in the hollow of the sacrum a retrodisplacement exists which must be corrected, or neglect to do so may result in abortion, incarceration of the gravid uterus, rupture of the bladder from pressure of the displaced cervix against the urethra, gangrene of the colon from pressure, and death from general sepsis. The simple replacement of the uterus during the early months of pregnancy, and its retention by a pessary for a few weeks until by its growth it is too large to again fall back into the pelvis will prevent further trouble, unless adhesions exist where other measures will have to be used which will not be spoken of here. Next, the pelvic diameters should be carefully estimated particularly by those who practice amongst the foreign born, as they are more subject to ricketts, Pott's disease and other bone lesions, which cause pelvic deformity than the native American. The pelvimeter is a valuable aid at this time. After the sixth month one may determine the presentation and position of the fetus, and if placenta previa be present it may be recognized and ample time had to outline a plan of treatment. From the above it may be seen what an immense amount of necessary knowledge may be obtained by the expenditure of a little effort on the part of the doctor, and after all he has but done his duty.

LABOR.

If the advice as outlined is followed the time of labor need cause the attendant no anxiety as he has intimate knowledge of the case from the beginning, and has put his patient in the best possible condition to successfully withstand the arduous process of labor. But here is where the doctor himself may prove disastrous from lack of thorough asepsis in his examination. It is more necessary for the obstetrician to be clean than the abdom-

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inal surgeon, who has always been exploited as the ideal in that respect, when the honor should go to the obstetrician. A vaginial examination during labor is never free from danger, so strict asepsis is the rule. As a preliminary the bowels and bladder should be emptied, the external genitals and surrounding parts should be carefully scrubbed with warm water, green soap and soft sterile brush or absorbent cotton, then irrigated with 1 to 2000 sublimate solution, and lastly sterile water. It is my custom in addition to the above to shave the lower portion of the vulva; by so doing you minimize the danger of subsequent infection from clotting of the lochia about the vulva, which may in future be kept clean by simple irrigation with sterile water. The physician should prepare himself with equal care. He should scrub his hands and arms thoroughly with a stiff nail brush, green soap, and, preferably, he should wash in running water, after scrubbing the hands should be immersed in sixty per cent alcohol, then 1 to 2000 bichloride, lastly in sterile water; sterile rubber gloves may be worn as an additional precaution. Over the street clothes should be worn a sterilized gown. If we have examined the patient a few weeks prior to labor, it would seem unnecessary to repeat the operation during labor when the danger is greater. Theoretically, we should be able to tell when the os has dilated without an examination, as cervical dilatation is accomplished by the uterine muscles alone, and when the abdominal muscles are brought into use we know that dilatation is complete; and the second stage of labor begins. But it is not necessary to rely upon this rule if we will but be clean.

The passage of the presenting part (normally the head) through the vulvar orifice calls for intelligent management if we would protect that complex structure, the perineum from injury. Usually with care the perineum will withstand the passage of the head without rupture, and all would be well if the doctor did not get in too big a hurry to complete labor. After the birth of the head no effort at extraction should be made until the next step in the mechanism of labor has occurred, namely, anterior rotation of the shoulders. After the birth of the head, time must be given for the shoulders to rotate into the antero-posterior diameter of

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the pelvis. If traction is made before rotation we pull the bisacromial diameter transversely through the vulvar orifice and perineal laceration results. By simply supporting the head and waiting for rotation the shoulders will be born by the natural forces, with little or no injury to the pelvic outlet.

As mentioned, the bowels and bladder should be emptied before the second stage of labor, as distension of either may act as an impediment to proper descent and mechanism; the posterior bladder wall may be caught between the pubic symphysis, and the presenting part, and subjected to sufficient pressure to produce necrosis and fistula. Or a portion of the rectal contents may be forced out and contaminate the external genitals and infection result from the colon bacillus.

With the birth of the child and ligation of the cord the third stage of labor is inaugurated. Tying of the cord is not devoid of importance. As a general rule it should not be ligated until pulsation has ceased. Some writers claim that premature ligation of the cord deprives the infant of about three ounces of blood, to which it has a right. A recent method is to tie the cord a second time (after the completion of labor) by transfixing it with a needle threaded with catgut, which is tied in a pedicle knot, cutting off the excess and applying 80 per cent alcohol to the cut surface, covering with sterile gauze or cotton. The treatment of the third stage of labor has for its object the securing of firm uterine contraction and the expulsion of the placenta and membranes. Firm contraction of the uterus is the key to the prevention of post-partum hemorrhage. As soon as the second stage of labor is completed the fundus of the uterus should be grasped firmly through the abdominal wall by an intelligent assistant and kneaded vigorously until it is felt to firmly contract. The uterus should not be allowed to get beyond control, but gentle kneading and rubbing be continued to maintain contraction and retraction. It is hardly ever necessary to invade the uterus for removal of the placenta, spontaneous delivery is the rule unless the physician gets anxious and pulls on the cord which may result in tearing the placenta, leaving a portion behind, or inversion of the uterus may follow such action. If expulsion of the placenta

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needs to be aided the well known method of Crede is probably the best. Care, however, must be taken not to make lateral pressure for fear of injuring the appendages. With the fingers grasping the fundus with the thumb anterior, pressure should be made downward and backward in the pelvic axis, which will result in the placenta being expelled from the vagina, from which it is received by the hand of the physician, being careful to see that the membranes are complete. After the patient has rested the external genitals should be examined for possible injury, the character of the lochia should be noted. If there is an excess of arterial blood in the discharge it is probable that the circular artery of the cervix has been torn and profuse bleeding may result in spite of the fact that the uterus is contracted. We must immediately look for the source of bleeding, place patient in lithotomy position in a good light, introduce a sterile speculum, which will enable you to discover the source of bleeding, and apply the proper remedy. Such a case demands immediate repair of the cervix, the torn surfaces are coapted and sutured with chromic gut, when arterial bleeding will cease. If the perineum is lacerated it should be promptly repaired. Simple suturing of the vaginal mucous membrane does not repair an extensive injury, we must seek out the torn ends of the perineal muscles and suture one to the other in their proper relation. For the convenience of the operator and the future comfort of the patient it is better to deliver all women on a properly prepared table. Such a table may be had in any home. A kitchen table covered with a blanket and clean sheet answers all the requirements. The physician should provide a rubber pad to put under patient, which is covered when needed with a towel sterilized by boiling. The use of the table avoids soiling the bed, and any operative procedure necessary is carried out to better advantage.

PUERPERIUM.

This covers the period from delivery to complete involution of the uterus, extending over about eight weeks. In normal cases the first two weeks should be spent in bed. An abdominal binder should be worn, as it does no harm and gives comfort to the patient. No special pad should be placed over the uterus, except

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where hemorrhage is feared, as it predisposes to retrodisplacement. The lochia should be received on pads specially prepared, clean (?) rags should not be used for such purposes. A sufficient number of pads should be prepared in advance, composed of absorbent cotton enclosed in gauze. Pads may be sterilized by dry heat in an ordinary bake-oven. They should then be kept in a covered glass jar, and removed one at a time with clean hands, as needed. A T bandages should be used to hold them in place, the vulva being cleansed, at each change by irrigating with sterile water. The preliminary shaving before referred to makes the care of the vulva a simple matter. A vaginal douche should never be given. Investigators have shown that the healthy vagina is free from disease-producing organisms. As a matter of fact the secretions from the normal vaginal mucosa are bacteriocidal and protective. Normal cases should remain free from fever. For the first few hours after delivery the temperature may be slightly subnormal on account of exposure, loss of blood and loss of the body heat of the fetus, but it soon returns to normal, and should stay there. The so-called milk fever about the third day is a myth. One must not forget that fever from infection is manifest about the same time. Fever may occur from the absorption of toxins from the intestinal tract, but it subsides after free purgation. But any rise in temperature during the puerperium needs close watching. After-pains may be so severe, especially in multipara, as to be mistaken for a beginning peritonitis, but a differentiation is not difficult. In peritonitis the pain is more diffuse and continuous abdominal tenderness and swelling, is marked, fever is present, lochia is diminished or suppressed, and there is general systemic disturbance and vomiting. After-pains are intermittent, lochia is increased, clots are expelled by the uterine contractions, temperature remains normal, and there is no vomiting or general disturbance. A useful prescription to assist involution, and for its tonic effect is:

Ergotin ..... gr. ii
Quin. sulph. ..... gr. ii
Ferri sulph. ..... gr. ii
Strych. sulph. ..... gr. 1-60

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To be given in pill or capsule three times a day until patient is out of bed. The care of the bladder is important. If a catheter is used it should be boiled each time, just before using, the meatus and surrounding parts should be cleansed gently with cotton and boric acid solution, the parts should be exposed enough to see what one is doing. Carbolized vaseline should be used as alubricant. When a catheter is being withdrawn the end should be covered with the finger to prevent the urine in the tube from dribbling over the vulva. Patients should be induced to pass urine normally as soon as possible, even to getting out of bed for that purpose. For the engorgement of the breasts dry hot applications, massage, saline purgation and the breast pump should answer the indications. After nursing, the nipples should be carefully washed with a saturated solution of boracic acid and bathed with dilute alcohol. Care must be taken to prevent erosion of the nipple, or infection and abscess may result. Women should avoid heavy work or violent exercise for at least two months after delivery, or until involution is completed.

The object of this paper is not to advance any new ideas, but simply to repeat some well known truths which are too often forgotten or overlooked, and to impress upon the practitioner the importance of his obstetric duties.—*Medical Fortnightly.*

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Extracts from Home and Foreign Journals.

SURGICAL

Appendicitis and Jaundice.

The appearance of icterus during the course of an appendicitis or following an operation for the relief of the latter condition has probably been observed by most surgeons, yet we find but scant notice taken of this complication in the very voluminous literature on the subject of appendical disease. That the condition is not infrequent is shown by the Statistics of Reichel (*Zeitschrift fur Chirurgie*, Vol. 83, No. 1), who found that among 165 of his cases of appendicitis jaundice had been noted in 18, and of these 10 resulted fatally. These mortality figures seem to afford sufficient reason for us to look upon this complication as indicating a very unfavorable prognosis. The type of jaundice under consideration is neither catarrhal nor obstructive, but is an indication of a general septic infection, the origin of which must be sought for in the inflamed appendix or its mesentery. Of quite a number of patients operated upon during the interval, Reichel found jaundice occurring in only one, and here the wound had suppurated.

Icterus, as a complication of appendicitis, usually occurs within thirty-six to sixty hours after the beginning of the attack, and unless it subsides in a short time is rapidly succeeded by a condition of restlessness accompanied by a rise in the pulse rate, but not of the temperature. Reichel compares the clinical picture to that which we find associated with acute iodoform poisoning. In most cases the patients became delirious, then deeply comatose, and death followed in twenty-four hours. The fatal issue can only be ascribed to a severe and virulent septic infection, and this may be unaccompanied by peritonitis. In such cases not even an early operation will avert the unfortunate outcome. Reichel claims that the liver becomes involved by the transmission of masses of bacteria or infectious thrombi through the medium of

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the portal circulation. It would seem wise, therefore, to restrict all handling of the affected organ during an operation as much as possible, and the writer even urges that after forty-eight hours operative interference be limited to the evacuation of any abscesses which may be present.—*Medical Record.*

Chronic Appendicitis Without Definite Attacks.

The history of most cases shows that the atypical forms become well known long after the typical ones are generally recognized. This is true of appendicitis, in which disease the classical picture with acute onset, localized pain and tenderness over McBurney's point is now known to every physician, but certain chronic forms are less often recognized. The fact that there are chronic cases in which there are no definite attacks and but few symptoms directly referable to the appendix has been recognized for some years. Ewald spoke of this type of appendicitis as "appendicitis larvata," but the term has not come into general use. There is little doubt that cases of this character are frequently overlooked and diagnosed as intestinal indigestion or dyspepsia. They do not belong to the class of cases which reach the surgeon early, and, as a rule, the surgeon is more expert at detecting the atypical varieties of appendicitis than is the general practitioner.

The clinical picture presented by these patients has recently been summarized by Klemm. At first sight the patient gives the impression of one suffering from some chronic gastrointestinal disorder rather than from a localized condition. The symptoms are mainly those of a catarrh of the large intestine, and many cases are so diagnosed. The patient may have diarrhea or constipation, or the two conditions may alternate; there is often a feeling of fulness and discomfort after meals, some pain in the neighborhood of the right iliac fossa is rather common, and this may radiate to the epigastrium, the umbilicus, or the left side. The pain is increased by long standing or even long sitting, is severe enough to make the patient restless and irritable, but is at first not wearing enough to lead him to consult a physician. Stomach symptoms may occur in some patients, but are not so common

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as intestinal ones. When present they take the form of anorexia or eructations occurring immediately after meals.

Physical examination of these patients shows in many instances some tenderness over McBurney's point and at times a palpable appendix. In some cases there is a visible swelling in the right flank from a gas-filled cecum, the so-called "air-cushion" symptom. In occasional patients there is a slight daily rise of temperature above the normal and persisting for months. The recognition of this type of appendicitis is important, as the condition is intractable under medical treatment, and is only to be permanently remedied by operation.—*The Journal.*

Chloroform: Its Indication and Advantages.

Thornton writes under this caption in the *Southern California Practitioner* for November, 1906.

Ether, chloroform, and the mixtures each have their advocates, and conflicting statements force the reviewer to form his own conclusions, largely from his personal experience and his knowledge of the physiological action of the various anesthetics.

The depressing action of chloroform on the heart and respiration and its tendency to lower blood-pressure will, in the opinion of the author, always make ether the anesthetic of choice in the average operative case.

Also the secondary toxic effects directly due to the anesthetic employed have been shown to be greater in chloroform than ether. This is especially important in operations requiring considerable time.

The ever-present financial consideration, the ease of administration, the pleasantness of the drug, the quickness of its action, and the small quantity required are some of the factors leading most of us to always carry a bottle of chloroform.

Plethoric subjects with full, bounding pulse, whose heart's action calls for a sedative rather than a stimulant, do far better with chloroform than ether.

Atheroma, arteriosclerosis, aneurism, and conditions of weakened vessel walls forbid the stimulating effect of ether. In opera-

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tions for the relief of cerebral hemorrhage, brain tumors, and in most of the cases of brain surgery, chloroform is the better anesthetic.

As choroform does not excite an excessive secretion of saliva and mucus its use is preferred in operations about the mouth, larynx, and upper air-passages; especially is this true where the mirror is to be employed.

Chronic diseases of the lungs are said not to contraindicate ether.

Acute inflammations of the lung tissue and bronchi give chloroform the preference.

On account of the toxic effects of chloroform on already diseased hepatic cells, ether is the anesthetic in liver surgery.

In nephritis, opinion is divided between ether and chloroform. Because of the increased blood-pressure and the fact that most of us were taught that ether was an irritant to these cases, chloroform will be chosen.

In administering ether to alcoholics the only effect produced may be a comfortable "jag" for the patient, and chloroform will be substituted.

Among Western and Southern men chloroform will be used in obstetrics. Its effects in these cases have been a source of wonderment. Oftentimes in forceps deliveries we are compelled to trust its administration to a member of the family or an indifferent nurse, and rare indeed are the accidents following its use. The patient quickly awakens and nausea is almost unknown.

Chloroform will be used in operations requiring but little time, especially with children and the aged.

The ideal anesthetic perhaps is yet to be considered, but when the author's appendix is removed he asserts he shall insist that ether be employed by the open, that is, by the drop-by-drop, method.—*The Therapeutic Gazette.*

Accidents in Thoracentesis.

Waldvogel writes from Ebstein's clinic at Gottingen to describe a case of hemorrhage and another of albuminous expectoration after puncture for protracted pneumonia with great dyspnea and

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effacement of the interspaces. The first patient was a child and the trocar pierced the intercostal artery, as the autopsy the next day revealed. The hemorrhage had been spontaneously arrested as the coagulum compressed the wound, the rigid lung not yielding. The first effects of puncture had been apparently beneficial, and it was repeated on the other side the next day. As the aspirated fluid showed traces of blood toward the last, the trocar was withdrawn. In a second case a girl of 17 had been operated on the previous year for a tuberculous process in the scapula. Puncture for a left pleural effusion allowed the escape, without aspiration, of a liter of blood-stained fluid containing much albumin. The effusion required tapping again a week later, the fluid showing the same characteristics. The heart action was bad and the liver, spleen and stomach showed much congestion, with ascites, development of a pleural effusion on the other side, and pulse of from 120 to 156. Another puncture, about three months after the first, allowed the escape of about 1.5 liters, without aspiration, of a turbid yellowish fluid. The patient began to cough, and at the change from the sitting to a somewhat reclining posture the cough and dyspnea increased and a foamy, slightly reddish fluid was expectorated. The cynanosis increased and the patient died in twelve hours. The amount of fluid thus expectorated was about 1.5 liters and it contained 3 per cent. albumin. Fully 2 more liters were found in the pleural cavities at autopsy. Experiments on dogs and rabbits are related and the clinical data analyzed to explain the mechanism of these mishaps and means to prevent them. The chief preventive measures are early puncture, prevention of coughing by administration of sedatives, before attempting the puncture, and, finally, stimulation of the heart. The last two measures, he states, should be tried in treatment.—*The Journal.*

Surgery of the Spinal Cord.

The surgical diseases and lesions of the spinal cord, contusions, concussions, punctured wounds, hemorrhage, fractures and dislocations, gunshot wounds, spina bifida, syringomyelia, etc., and their management, are reviewed by J. B. Murphy, Chicago (*Jour-*

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nal A. M. A., March 2). He holds that when the axions and ganglion cells that make up the substance of the cord above the cauda are destroyed, regeneration is impossible, and, therefore, in gunshot or stab wounds, with immediate paralysis, operation is useless as regards hope of repair, except in the caudal zone, where the possibilities are the same as in the case of wounds of peripheral nerves. Hemorrhage, concussion and contusion without laceration may give rise to the same immediate symptoms as division, and a positive differential diagnosis is impracticable. The time and order of appearance of symptoms may be the only guides; there is no direct relation between the severity of the trauma and the degree of injury to the cord. Absence of immediate paralytic symptoms is not a guide—they may appear after days or weeks. Early spinal punctures may relieve paralysis due to hemorrhage which in some cases may be as complet as that due to division of the cord. Most patients with incomplete paralysis following fractures recover without operation, and when the displacement is not great the physician is justified in assuming that the cord is not suffering continuous compression and in refraining from operation. The special indications as regards operation in the various conditions above enumerated are pointed out and the technic of laminectomy is described. The danger of delay in conditions calling for operation, especially in non-malignant tumor, tuberculosis, etc., is emphasized. Late operations after necrosis in the cord has taken place are worthless. Surgery of the spinal cord, like surgery elsewhere, must be timely, i. e., before the pathologic condition has passed the possibility of repair.

The Hand of Iron in the Glove of Rubber.

Robert T. Morris says that rubber gloves lead to slow work, which further reduces the natural resistance of patients. He declares that what the patient needs is simple, quick work, which merely turns the tide of battle between bacterium and phagocyte. We need discrimination more than we need rubber gloves. Rubber gloves, the writer says, may be useful in cases in which there is no infection of other disease to call out the patient's natural resistance to infection in cases in which dressings are to be

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changed for several patients in succession, or when the surgeon operates upon an uninfected patient shortly after operation upon infected one. Rubber gloves are not needed—or worse than that —in cases in which infection is already under way, when a disease like cancer has already called out such a degree of protection that a breast could be amputated and primary union obtained under "well-waxed shoemaker's thread" that had been held in the mouth, or when no infection or other disease is present, but where slow operating in gloves will allow more bacteria to fall into the wound than would be carried in by well-prepared bare hands.—*Medical Record.*

Harmful Involution of the Appendix.

Robert T. Morris draws attention to the fact that the normal involution of the appendix, with replacement of the lymphoid, mucous, and submucous coats by connective tissue, may produce unpleasant symptoms for a long period and thus become harmful to the patient. Nervous filaments persist longer than the other structures and scar tissue presses on these nerve endings and produces pain, symptoms of intestinal dyspepsia and distention of the cecum by gas. The process is distinctly irritative, not infective. Involution seems actually to guard patients against infection. Normal involution of the appendix may begin early in life; but most patients who show its symptoms are over twenty-five years of age. Connective tissues replacement usually progresses from the distal extremity; rarely it occurs in nodes, producing bulgings between. In most cases the proximal portion of the appendix is still open and lined with a thin mucosa. Symptoms begin gradually; there is autointoxication, with its train of symptoms, and there are intestinal dyspepsia, sensation of discomfort in the region of the apendix, an appendix that feels hard and narrow on palpation, and hyperesthesia of the lumbar plexus of nerves. There is persistent distention of the cecum and colon with gas. Irritation of the nerve filaments is communicated to the intimate ganglia of the bowel wall and causes disturbance at the nearest point of the bowel. The sensation of discomfort in the appendical region is not due to distention with gas, but to

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direct irritation of nerve filaments. We have to diagnosticate the involutional appendix from the scar appendix and Edebohl's appendix. The scar appendix gives a history of previous infection. Edebohl's feels plump from interstitial exudation, while the involutional appendix is hard and firm, and is never the seat of infection. Hyperesthesia of the lumbar nerve plexus is found by pressing deeply on either side of the navel. From gall-bladder cases it is distinguished by predominance of gastric and gall-bladder tenderness. It is best not to remove these appendices, unless demanded by the patient.—*Medical Record.*

New Method of Wound Dressing.

In his work on the Russo-Japanese war von Oettingen describes a new method of wound dressing which he employed in thousands of cases. He and his colleagues in the field hospital never attempted to cleanse the wounds; thy painted the surrounding area with a solution of mastic, placed a collargol tablet into the lesion, covered it with a sterile cotton pad, and applied a bandage. The mastic "arrested" the bacteria on the skin and prevented their migration into the wounds, especially because the dressing was immovable. The tablet immediately dissolved and penetrated into the crevices, whence the silver was absorbed. Collargolum has an indubitable antiseptic action and does not coagulate blood serum, so that the secretion flows on freely till the wound is clean; then a scab forms, which soon drops off from the cicatrix.

He also used a 3-per-cent. collargol-lactose dusting powder, which is even cheaper than iodoform, as well as 1:500 to 1:000 solutions for irrigating facial sinuous wounds, the bladder, the urethra, etc. At laparotomies a 1:100 to 1:500 solution was poured into the cavities.

Collargol is a surgical antiseptic to which no objection can be raised; it is non-toxic, non-irritant, and obviates the need of working in phenol or lysol odors. The bichloride in the first-aid packages should be replaced by collargolum, this giving a non-toxic antiseptic bandage kit.

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MEDICAL

Benzin Arrests Transient Redness of the Nose.

F. Bruck states that a single application of petroleum benzin on cotton or lint will at once arrest the tendency to redness of the nose from strong coffee or tea, emotions, or exposure to cold or heat, observed in some individuals. The benzin will also abolish the shiny aspect of the nose occurring with the hyperemia or without it. The benzin-impregnated cotton is pressed on the spot for a few seconds, without rubbing, covering merely the reddened parts and taking care not to allow the benzin to get into the eyes, nostrils or mouth. In a communication on the subject to the *Med. Klinik,* Feb. 3, 1907, Bruck states that the petroleum benzin does not have the slightest irritating action on the skin, and is by far the best method of cleansing the skin in acute eczema or similar conditions.—*The Journal.*

Digitalis in Valvular Heart-Disease.

The writer states that digitalis should seldom, if ever, be given in cases of aortic regurgitation which has developed during or after middle life, since the ventricular wall is seldom perfectly sound under these circumstances; and never in patients who give evidence of myocardial degeneration or disease. If complete rest is obtained, digitalis is permissible and beneficial up to a certain point in young, otherwise healthy adults showing signs of circulatory failure, more especially when the aortic lesion is combined with mitral incompetence. The drug should be discontinued for some time before exercise is resumed, and this rule should be rigidly observed. Neglect of this precaution might be followed by rapid failure of the ventricle and sudden death. Theoretical considerations suggest that the utility of digitalis in aortic incompetence is strictly limited. It may be accepted as a good working rule that digitalis is beneficial in cases of aortic incompetence proportionally to the magnitude of the stress which has led to failure of the heart, and vice versa.

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Digitalis is contraindicated in aortic stenosis apart from the appearance of cardiac failure. The author endorses the use of digitalis in cases of mitral insufficiency, but in mitral stenosis it can be of no benefit in the absence of failure of the right ventricle, and in this event, as long as the pulmonary blood-pressure has been raised to the point at which the maximum charge of blood is delivered to the left ventricle, the drug will again act prejudicially. W. W. Colbeck (*British Medical Jaurnal,* Dec. 1, 1906).

Internal Hemorrhage—Treatment by Milk Enemas.

Remarkable results are reported by Solt (*Therapeutische Monatschefte,* No. 10, 1906) from the use of enemas of milk, warmed to body temperature, and best introduced by a piston syringe; the intermittent flow gives better results than a constant stream from a fountain syringe. He has stopped a large number of hemorrhages from the uterus, bladder, stomach, lungs, and in fact from every part of the body. In some cases more approved hemostatics had been used for hours without result, and the milk was immediately successful. At least a quart should be given at once, with nothing added but a little salt to make it absorb more rapidly. The enema should be repeated in an hour, even if there is no return of the hemorrhage. The usual local measures are employed at the same time. The method of its action is not certain, but milk contains a large number of substances which are recommended as hemostatics—iron, phosphoric acid, sulphuric and citric acids, but above all, lime salts. The enzymes and leucocytes also tend to cause an increase in the fibrin ferment. The milk loses its hemostatic power if it is given by the stomach.—*The Therapeutic Gazette.*

Ulcer of Duodenum.

Robson discusses the clinical history of duodenal ulcer in great detail and expresses an opinion that the operation of posterior gastroenterostomy is the treatment for this affection. He has operated on 66 patients without a single fatality. Among 155 cases of acute perforating duodenal ulcer recorded in the litera-

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ture there was a mortality of 66 per cent. Sixty-one patients were operated on within 24 hours of rupture, with a mortality of 37.7 per cent; whereas among 63 patients operated on later than 24 hours after rupture the mortality was 82.5 per cent. Of 31 cases in which the time of operation was not stated, but in which the time was probably over 24 hours after rupture. 90.3 per cent proved fatal. Robson says that it is astonishing to find how long in many of the cases of duodenal ulcer the symptoms persist, the patients being treated for dyspepsia, gout, gastroduodenal catarrh, neurosis, chronic appendicitis, etc. In some of his cases a 10, 15, 20 or even 30 years' history of dyspepsia had been given, with characteristic symptoms throughout and with irregular intervals of relief by treatment and relapses every few weeks or months. He thinks that duodenal ulcer is much more common in early age than is generally recognized, although the condition as usually diagnosed is seen for the most part in the middle-aged.—*The Journal.*

Cerebral Syphilis in Childhood.

A. W. Fairbanks, Boston (*Journal A. M. A.*, March 9-16), uses this designation of his subject, as possibly many cases of syphilis developing late in childhood are acquired, rather than hereditary. Hereditary syphilis, he states, is deserving of much more attention than it has received. The three pathologic conditions of cerebral syphilis in the order of their apparent frequency of occurrence: Meningitis (principally leptomeningitis); arteritis (usually endarteritis); and syphilomata (usually of meningeal origin). All other changes are probably secondary to these. The characteristic symptoms of syphilitic lesions are their multiformity, their usually subacute onset with occasional acute and severe individual symptoms. These latter often disappear unexpectedly and recur in the same of other localities, eventually becoming permanent. Lastly there is the striking amenability of some of the symptoms to specific treatment, while others are most resistant. The symptoms are manifold, but some one type usually predominates at some period of the disorder. Psychic changes occur early, but are often unobserved and lacking in the

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history. Other symptoms, motor and sensory, make their appearance before the psychic changes are fully recognized, such as vertigo, frequent speech aberrations, visual disturbances and attacks of syncope. Later capillary phenomena, epileptiform, or hemoplegic attacks appear. Early recognition of the condition is very important and evidence of hereditary syphilis in the family history should be diligently sought. The prognosis depends largely on the pathologic type, the determination of which is not always easy. The purely gummatous symptoms are usually amenable to specific treatment and simple meningeal conditions are also commonly favorable, while arterial lesions are the worst. External injury often precedes the outbreak and is considered the cause. While the author does ont think this commonly the case, he admits the possibility that the impaired brain may be a point of least resistance.—*The Journal of A. M. Association.*

White-Wine Whey in Infant Feeding.

Myers and Still are very favorably impressed with the value of sherry-whey or white-wine whey as an infant's food, but state emphatically that like any other food which contains alcohol it should never be given to infants in larger quantities or continued for a longer period than the exigencies of the case require. They have often used it as the only food for a week or ten days, or given at alternative feedings, for two or three weeks. The whey is prepared by heating ten ounces of milk until just boiling, then adding two and one-half ounces of sherry, heating the mixture until it begins to boil up, when it is removed from the fire and allowed to stand a few minutes. The curd is then strained off through muslin. The whey is used when only small quantities of food can be tolerant and when a stimulant is necessary. To an infant six weeks old a tablespoonful can be given every half hour or every three-quarters of an hour, and the amount and interval gradually increased until two ounces are taken every two hours. In exceptional cases they have given three ounces, every three hours, to infants six months old, and even four ounces, every four hours, for two or three days, to an infant twelve months old. —*The Journal.*

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Oranges as Medicine.

There is no doubt that pure fruit juice is one of the best blood purifiers and system regulators that we possess—in fact, there are many who can testify to this fact, particularly as regards oranges. Some people who have hitherto eaten fruit between meals, or just before going to bed, and condemned it as injurious, have learned to eat one or two oranges with nearly every meal, particularly breakfast, and have found to their pleasant surprise that it exercised a marvelous effect upon their general health. Many remarkable things have been claimed for oranges taken as a food, such as making the complexion clear and beautiful, curing the drink habit, and numerous other things as varied as marvelous, and there are doubtless persons who have made themselves ridiculous eating oranges by wholesale in the endeavor to cure every disease to which flesh is heir. Thousands of persons can testify, however, that a judicious use of oranges is a good thing, but a few precautions must be taken. In the first place, buy nothing but good fruit, especially ripe fruit. Green or bad fruit can not be good for anybody. Then be careful to peel your orange carefully, for the white pith lying beneath the yellow rind is one of the most indigestible substances known in the vegetable world. Do not eat too many oranges at first; but if the habit once formed, a person will never be satisfied to eat a meal without fresh fruit of some kind.—*Health.*

Turnip-Top Treatment of Chronic Diarrhea and Dysentery.

C. Wilson and H. E. Pressly, Birmingham, Ala., (*Journal A. M. A.*, March 9), report six cases, four of chronic diarrhea and two of amebic dysentery, microscopically diagnosed, which were successfully treated with a diet of "greens" composed of turnip tops. One of these patients, one going where the diet was not to be had, suffered a relapse and died, the others continued well. Other vegetables, such as mustard, phytolacca and spinach are also mentioned as having been used to some extent. The attention of the authors was first called to the remedy by the recovery

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of an apparently hopeless case on "poke salad" (phytolacca) after leaving their care. Of the two cases of amebic dysentery, one patient had tried all the ordinary remedies and was ready to undergo an appendi custom y or an enterostomy if it would relieve him, as his condition was extreme. The other was not so bad, but had given up his work and never expected to be able to take it up. Both made good recoveries under the "turnip greens" diet. Wilson and Pressly have also tried it in two cases of well-defined gastric ulcer, in one successfully. The other patient was nearly moribund, and while he was able to take the diet better than anything, it failed to save him. The method of cooking is important, as it is very unpalatable if not prepared. As prepared as a domestic dish in the south, ordinary bacon is used, boiled half an hour, and then the turnip tops, spinach, mustard of phytolacca tops are added and allowed to boil from one to two hours.

A New External Hemostatic.

Schadel speaks well of the use of potasium permanganate as a hemostatic which was recommended recently by Vorner. The remedy was first applied in powder form mixed with charcoal in the proportion of three to one; but it was later found more convenient to use it in the shape of a paste. This may advantageously be prepared by the addition of about four per cent. of vaselin. It has been used with good success in all forms of parenchymatous hemorrhage such as follows the excision of condylomata, warts, etc. It has also been found of value in nasal hemorrhage and in lupus. The hemostatic is applied by carefully drying the spot in question and then pressing some of the paste directly onto the bleeding surface. Slight burning is caused, but the sensation is not very painful.—*Int. Therap.*

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OBSTETRICAL

Prognosis of Operative and Other Trauma for Continuance of Pregnancy.

Neu relates a number of instances of various traumata and the effect on the pregnancy. In one case severe hemorrhage from a varix in the vulva was followed by the death of the seven-months' fetus. The varix burst during an effort at stool. In another case a couple of cystic nodules in the vagina were excised for examination, followed by severe hemorrhage and the almost immediate death of the fetus. In another case a iii-para with postpartum stenosis of the vagina was operated on at nearly the third month of pregnancy. The cicatricial septum was excised and the circular wound in the vaginal mucosa sutured with catgut, without interfering with the pregnancy. In another case empyema of the gall bladder with diffuse peritonitis, temperature of 40.2 C. and pulse 120, in a ii-para of 29, at the fifth month of pregnancy, required a laparotomy, but the gall bladder was not opened. The incision was merely tamponed at first and sutured later, and the symptoms subsided with normal delivery at term. The diagnosis wavered between empyema of the gall bladder and appendicitis. A gallstone operation became necessary afterward and a stone was found in the common bile duct. The findings at that time indicated that a spontaneous anastomosis between the common bile duct and the duodenum must have followed the previous operation. Extensive adhesions had evidently developed later, and the suppurative cholecystitis must have perforated. Whether this spontaneous cure would have occurred without the incision and tamponing is a question. The fever and icterus vanished and the tumor became smaller soon after the first laparotomy.—*The Journal.*

Open-Air Treatment of Septicemia in Lying-In Hospitals.

Dr. William S. Stone read this paper. During the period Dr. Stone was connected with the New York Lying-In Hospital he had daily opportunity of observing the course of severe puerperal

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septicemias treated in the glass-covered solarium as compared to the course of the disease in the closed wards, and he gave a few general conclusions based on his own observations. From the patient's point of view it was surprisingly satisfactory. The restlessness and delirium were less frequent and less marked. To the casual and untrained observer the sight of these patients on the roof under their green-lined sunshades might suggest a number of well-to-do convalescents enjoying the advantages of a Southern climate, rather than tenement dwellers filled with unnumbered streptococci striving to destroy their host. Like typhoid fever, puerperal, septicemia was accompanied by high fever, whether treated in the open air or in the closed ward, but in some cases the duration of the fever seemed to be shortened, and in all cases was better borne as expressed by the pulse and temperature. Pneumonia appeared to be less common and more transitory when it did occur. One of the strongest impressions made upon Dr. Stone was the difference in the general appearance and strength of the patients soon after the disease had run its course. Some cases got well, about which even the most sanguine observer would ordinarily only express a hopeless prognosis. The general conclusion that the reader of the paper drew from these observations was that any lying-in hospital that failed to provide suitable accommodations for the open-air treatment of child-bed fever was lacking in one of the most important means for promoting the comfort and the saving of lives that were intrusted to their care. *Medical Record.*

Treatment of Eclampsia.

Dr. John C. Hirst's conclusions as to the treatment of eclampsia, based on the cases at the University of Pennsylvania Maternity, were as follows:

The routine treatment consisted of: 1. Chloroform to avert the attack, if possible. 2. Fifteen minims of fluid extract of veratrum viride hypodermically. 3. Wash out stomach and through the tube introduce 2 ounces of castor oil and four drops of croton oil. 4. Hot vapor bath or hot pack, for thirty minutes, in every four hours. 5. Hypodermoclysis of one pint of salt solution under

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the breast every eight hours. 6. If convulsions recur, repeat the veratrum viride in five minim doses, every hour, for three doses, and then if blood pressure is still high and the patient is cynanotic, venesection is performed, removing from 8 to 16 ounces of blood. 7. Under ordinary circumstances let the labor alone. The use of morphin and pilocarpin is restricted to desperate cases only. Venesection is not done, as a rule, until veratrum viride has been given a trial.

Accouchement force is used only under the following conditions: 1. When the patient is far advanced in spontaneous labor, forceps are applied. 2. If patient is seen very early after the first onset of convulsions, it may be advisable to interfere. 3. If patient is going from bad to worse under treatment, the uterus is emptied as a last resort. The method employed is either vaginal hysterotomy (the so-called vaginal Cesarean section), and forceps, or the Pomeroy bag, followed by forceps. The latter method is probably the better. The cases studied were 88 cases of eclampsia and 278 cases of albuminuria. This treatment gave a mortality, excluding cases brought in in a moribund condition, of 13.4 per cent. Of the cases of albuminuria 40 had had eclampsia in previous labors (one four times), but escaped under treatment.—*The Journal.*

An Unusual Case of Sarcoma of the Uterus.

Von Wenczel (Zent. f. Gyn.) says the ratio of frequency of carcinoma to sarcoma of the uterus is placed at 24 to 1, and the site of sarcoma is mostly in the corpus uteri. For each time that sarcoma begins in the cervix there will be eight cases in which it will be found to have begun in the corpus. They start more often from the mucosa than from the outer wall of the uterus, and when from the latter origin they are usually the result of a degeneration of a fibro-myoma. The sarcomata developing in the uterine wall show the spindle-celled variety as occurring four times more frequently than the round-celled. Of the latter, the small-celled type is much rarer to meet than the large-celled type.

The author's case occurred in a woman forty-six years old, who had given birth to two children, and who since two years had complained of irregular menses. An ulcerated tumor of the cer-

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vix, the size of a child's fist, was discovered, and after curettage the cervix was amputated. Microscopical examination of the tumor improved it to be a sarcoma, and two weeks later the uterus was removed by vaginal hysterectomy. The operation was successful.

The microscopical investigation established the diagnosis of small type, round-celled sarcoma. The connective tissue of the mucosa was inflamed, and this inflammatory infiltration passed into the tumor without showing any sharp line of demarcation. No evidence of fibro-myoma was visible. Hence, the origin of the tumor was decided to have been in the cervix. From the inflammatory condition of the connective tissue of the mucosa it is also assumed that the tumor developed not from the mucosa, but from the wall of the uterus itself, and was a primary growth. —*The Lancet-Clinic.*

PREGNANCY FOLLOWING TRANSPLANTATION OF AN OVARY

A case more interesting from the standpoint of heredity than from that of surgery is reported by Cramar (*Munchener medicinische Wochenschrift,* No. 39, 1906), who saw pregnancy follow the intraperitoneal implantation of another woman's ovaries.

Cramer had in his clinic, at the same time, a case of osteomalcia, the best treatment of which is removal of the ovaries, and a case of superinvolution, in which atrophy of the ovaries and premature menopause had followed childbirth. He operated on both women at the same time, removing both ovaries from the case of osteomalacia, and splitting them and sewing them, with the cortex out, one against the denuded posterior surface of the uterus, the other against the similarly split atrophic ovary of the puerperal case. The wounds healed promptly, and two weeks later the first menstruation appeared in the puerperal case. Three months later she became pregnant, but aborted early. (If our ideas of heredity are of any value, the child if it had lived would certainly have been the offspring of the other woman. The idea of giving birth to another woman's child is a very suggestive one.) In another similar case the operation was a complete failure, the ovaries evidently not taking root.—*The Therapeutic Gazette.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages, at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

THE TENNESSEE STATE MEDICAL SOCIETY.

The Seventy-fourth Annual Meeting of the Tennessee State Medical Society was held in this city during three day—April 9, 10 and 11. The large attendance present, two hundred and thirty-five names having been registered, and the universal enthusiasm and good fellowship that prevailed was particularly gratifying. An unusually large number of valuable papers, and the valuable discussion of the same that was indulged in was a noteworthy indication of the interest shown in the representative body by its wide-awake members. The address of the President, Dr. L. A. Yarbrough, of Covington, Tenn., was delivered on the evening of April 9. On the same occasion an address entitled "Surgery of the Thyroid" was delivered by Dr. Charles Mayo, of Rochester, Minn. A special report on the Pure Food and Drug Law was made by Dr. A. B. Cooke, of Nashville, giving a short history of the passage of that valuable law. The papers read during the several sessions of the society were invariably of high character and scientific value, in every way worthy of the advanced and progressive standing of the practical profession of the Volunteer State. The officers elected at the meeting were as follows: President, Dr. A. B. Cooke, Nashville, Tenn.; First Vice-President, Dr. R. E. Fort, Nashville, Tenn.; Second Vice-President, Dr. C. P. McNabb, Knoxville, Tenn.; Third Vice-President, Dr. R. W. Tate, Bolivar, Tenn.; Secretary, Dr. Geo. H. Price, Nashville, Tenn.; Treasurer, Dr. W. C. Bilbro, Murfreesboro, Tenn.; Delegates to the American Medican Association,

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Dr. S. W. Woodyard, Greenville, Tenn.; Alternate, Dr. C. E. Ristine, Knoxville, Tenn. Next place of meeting, second Tuesday in April, 1908, Knoxville, Tenn. Much of the success of this meeting is due to the indefatigable efforts of the genial and accomplished secretary of the society, Dr. Geo. H. Price, who was, we are glad to say, elected to succeed himself in this responsible position.

DR. EDWARD C. REGISTER'S NEW BOOK.

"Practical Fever Nursing" will soon be issued from the press of W. B. Saunders Co., Philadelphia, Pa. Dr. Register is well known as the editor of the *Charlotte Medical Journal,* and as Professor of the Practice of Medicine in the North Carolina Medical College at Charlotte, N. C. Dr. Register is a widely traveled, well read and a polished, dignified gentleman. He has always enjoyed a large and lucrative practice in his home city as well as near-by towns and adjoining States. From his varied and ripe experience in the profession the doctor is in a position to write authoritatively on the subject of "Fever Nursing."—*Gaillards' Southern Medicine.*

ILLINOIS SCHOOL OF ELECTRO-THERAPEUTICS.
(*Incorporated.*)

SPECIAL NIGHT COURSE—THREE WEEKS, BEGINNING APRIL 8, 1907.

At the request of many physicians who desire to combine a course in Electro-Therapy with other post-graduate work, we have arranged this Special Night Course. Other post-graduate schools in the city will give special reduced-price courses at this time, thus enabling physicians to do work in General Medicine, Surgery, Gynecology, Otology, Rhinology, Ophthalmology, etc., and get a thorough course in Electro-Therapy at the same time. Abundant clinical material. The same work covered as in our regular day courses. Write at once for catalogue and information.

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A. H. ANDREWS, M. D., *Secretary.*
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OCCUPATIONAL DUSTS.

The American Institute of Social Service has received from Dr. Sommerfeld, a physician and scientist of Berlin, a valuable anti-tuberculosis exhibit for the department of industrial hygiene in its Museum of Security. There are 45 vials containing as many different kinds of dust, mineral, animal and vegetable, produced in our various industries. The same number of photographs show how these various dusts appear under the microscope. Extremely realistic models in wax, colored to life, represent human lungs as they are affected by occupational dusts, other models show normal lungs for comparison; whle still others show the effects of industrial poisons on the system.

At the meeting of the Executive Committee of the American Institute of Social Service held lask week at the Players' Club as the guests of Mr. Richard Watson Gilder, announcement was made that the *Scientific American,* through a desire to co-operate with the work of the Institute in promoting an American Museum of Safety Devices, would give annually a gold medal to be awarded by the Institute for the best device for preventing accidents.

An Advistory Committee of the editors of the great technical papers was organized to co-operate with the Institute in the work of protecting life and limb. As at present constituted the Advisory Committee consists of fourteen representatives from the *Scientific American, Iron Age, American Machinist, Railway and Locomotive Engineering, Automobile, Electrical World, Street Railway Journal, Dry Goods Economist, Electrical Age, Railway Gazette* and *Engineering and Mining Journal.*

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Reviews and Book Notices

A Manual of Obstetrics.—By A. F. A. King, M. D., Professor of Obstetrics and Diseases of Women in the Medical Department of the George Washington University, Washington, D. C., and in the Medical Department of the University of Vermont, etc. Tenth edition, enlarged and thoroughly revised. 12mo., 688 pages, with 30 illustrations and three colored plates. Cloth, $2.75 net. Lea Brothers & Co., Philadelphia and New York, 1907.

This well known book is beginning in its tenth edition, the second quarter century of its existence, and its present revised form appeals to the student and practitioner as a most successful claimant for patronage. In this edition the author has made such changes and additions as were rendered necessary by recent advances and improvements in this important department of practical medicine. It meets a want filled by no other book.

Essentials of Chemistry and Toxicology for the use of Students in Medicine.—By R. A. Witthaus, A. M., M. D., Professor of Chemistry, Physics and Toxicology in Cornell University. Thirteenth Edition. Revised by R. J. E. Scott, M. A., B. C. L., M. D., Author of "The State Board Examination Series." New York. Wm. Wood & Company, 1907.

The popularity of this useful little book is attested by its appearance in its 13th edition. The author's reputation as a chemist and teacher is ample guarantee of the scientific character of the work. It has been especially prepared to meet the need of the medical student, but is also well fitted to serve as a guide and reference book for the general practitioner. In this revision such changes and additions have been made as were deemed necessary to bring it fully up with modern requirements.

Practical Dermatology—A Condensed Manual of Diseases of the Skin; Designed for the use of Students and Practitioners of Medicine.—By Bernard Wolff, M. D., Clinical Professor of Diseases of the Skin in the Atlanta College of Physicians and

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Surgeons, Editor of the *Atlanta Journal-Record of Medicine;* Ex-president of the Atlanta (Fulton County) Society of Medicine; Ex-secretary of the Georgia State Commission on Tuberculosis, etc. Illustrated. Chicago, Cleveland Press, 1906.

The author of this volume has presented the salient features of diseases of the skin in such a form as will prove acceptable to students and practitioners of medicine. The study of diseases of the skin is a difficult one at all times, and any book that has a tendency to light up this dark subject should be welcomed by the profession. This manual seems to be well adapted for the objects the author had in its preparation, and should receive a widespread patronage.

Paraffin in Surgery—A Critical and Clinical Study.—By William H. Luckett, B. S., M. D., Attending Surgeon, Harlem Hospital; Surgeon, Mount Sinai Hospital Dispensary, and Frank J. Horn, M. D., Assistant Surgeon, Mt. Sinai Hospital Dispensary, New York City. With thirty-eight illustrations. Surgery Publishing Co., 92 Williams St., New York, 1907.

The use of paraffin in parosthetic surgery is comparatively a new thing of which but little is known generally. The author in this little work has arranged in admirable manner an exposition of the uses and means of using this agent in certain deformities that should prove invaluable to the practitioner.

Plaster of Paris and How to Use It.—By Martin W. Ware, M. D., Adjunct Attending Surgeon, Mount Sinai Hospital; Surgeon to the Good Samaritan Dispensary; Instructor of Surgery, The New York Post Graduate School, New York. Surgery Publishing Company., 92 Williams St., 1906.

An eminently practical guide for the practitioner, describing in systematic form the best means and methods of employing plaster of Paris in every day work. The book has much to commend it and will prove of great value to all who have occasion to consult it in their daily work.

Progressive Medicine.—A quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences.—Edited by Hobart Amory Hare, M. D., Professor of

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Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, etc. Assisted by H. R. M. Landis, M. D., Visiting Physician to the Tuberculosis Department of the Philadelphia Hospital, to the White Haven Sanatorium and to the Phipps Institute; Demonstrator of Clinical Medicine in the Jefferson Medical College. Volume One. March, 1907. Surgery of the Head, Neck, and Thorax—Infectious Diseases, including Acute Rheumatism and Croupous Pneumonia—The Diseases of Children—Rhinology and Laryngology—Otology. Lea Brothers & Co., Philadelphia and New York, 1907.

We are invariably pleased with the appearance of every number of this essentially practical and useful series. We do not know of a publication that carries with it so much valuable information in such readily accessible form. Every practitioner should avail himself of the opportunity afforded by this quarterly and subscribe to the work, for by its aid more than by any other he can keep himself *en rapport* with recent discoveries and improvements in every department of medicine.

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Publisher's Department

Liquozone Barred from Registration in U. S. Patent Office as Unlawfully Interfering with the Trade-Mark Glycozone.

Notice is hereby given that in a proceeding in the United States Patent Office, which is entitled *The Drevet Manufacturing Company vs. The Liquozone Company,* the name "Liquozone" was barred from registration in the U. S. Patent Office as unlawfully interfering with the trade-mark "Glycozone."

The individual or corporation in any way infringing upon the trade-mark "Glycozone" which is a legal trade-mark (Glycozone being a thoroughly scientific and legitimate preparation for the treatment of germicidal diseases, etc.), and duly registered under the new trade-mark law, or selling of any merchandise labeled with any mark or name infringing upon the trade-mark "Glycozone," or in any manner resembling the same, will be prosecuted for damages to the full extent of the law.

Pertinent Thoughts.

The epidemics of la grippe which have made their annual onslaughts for some years, have taught us that this disease, once considered of no serious consequence, is so dangerous and difficult to treat, that any suggestion regarding medication is always gratefully received.

With each succeeding visitation of this trouble, we have found it more and more necessary to watch out for the disease in disguise, and to treat these abnormal manifestations; consequently we have relied upon mild nerve sedative, anodynes and heart sustainers, rather than upon any specific line of treatment. Most cases will improve by being made to rest in bed and encouraging action of skin and kidneys, with possibly minute doses of blue pill of calomel. We have found much benefit from the use of Antikamnia & Codeine Tablets in the stage of pyrexia and muscular painfulness. This tablet, containing 4 3-4 grains anti-

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kamnia, and one-fourth grain sulphate of codeine, is a sedative to the respiratory centres. In the treatment of la grippe and its sequelæ, its value is highly esteemed. In diseases of the respiratory organs following an attack of la grippe, pain and cough are the symptoms which especially call for something to relieve. This combination meets these symptoms, and in addition, controls the violent movements accompanying the cough. To administer these tablets in the above condition, place one tablet in the mouth, allowing it to dissolve slowly, swallowing the saliva. Exhibited in the grinding pains which precede and follow labor; in the uterine contractions which often lead to abortion; in the various neuralgias, and in all neuroses due to irregularities of menstruation, this combination affords immediate relief. In these last conditions, always instruct that tablet be crushed before taking.

Louisville, Ky., October 11, 1906.

The Anasarcin Chemical Co., Winchester, Tenn.

Some time ago I received a sample of your tablets and I am glad to inform you that they have proved very satisfactory to me. Have found several occasions to prescribe and recommend them very highly. I would appreciate another sample if you care to favor me. Very truly yours,

JOHN D. CARPENTER.

Sodaville, Oregon, November 5, 1906.

The Anasarcin Chemical Co., Winchester, Tenn.

I received a sample of Anasarcin Tablets some time ago, for which accept thanks. I have been a sufferer from heart trouble, difficult breathing, especially when ascending a height, also dropsy of the feet and ankles for a number of years.

Your suggestion of its therapeutical action indicated that it might be applicable in my case. I commenced their use at once, taking one tablet after each meal. I took no other medicine. It wrought wonders in my case; I am almost well. I have taken a great deal of medicine from time to time but with little benefit until I took this. With my experience with these tablets I feel

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that they are entitled to all the credit that you claim for them. Your discovery of such a splendid remedy means much in the advancement toward a higher standard of medical remedies.

It affords me great pleasure to recommend your Anasarcin Tablets to patients and to the medical profession.

Respectfully,

D. M. JONES, M. D.

We call the attention of our readers to the advertisement of the Robinson-Pettet Co., Louisville, Ky., which will be found on another page of this issue. This house was established fifty years ago, and enjoys a widespread reputation as manufacturers of high character. We do not hesitate to endorse their preparations as being all they claim for them.

A physician makes the following statement:

"I consider Tongaline far superior to any preparation for rheumatism, neuralgia, grippe, gout and similar complaints, and it has given me such uniform satisfaction that I rely upon its action most implicitly.

"I was first impressed with the unusual merits of Tongaline by the great benefit which my wife derived from its use, and this was all the more remarkable because she tolerates salicylates in any other form very poorly, but whenever she feels the first symptoms of rheumatism, the attack is at once controlled by taking Tongaline for a very short time."

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. MAY, 1907. No. 5

Original Communications

CHARGE TO GRADUATING CLASS.

DELIVERED BY RICHARD A. BARR, M. D., PROFESSOR OF ABDOMINAL SURGERY, IN THE MEDICAL DEPARTMENT OF THE VANDERBILT UNIVERSITY, MAY 1, 1907.

It has always been my contention that speech-making by a member of a medical faculty on commencement occasion, is superfluous so far as the students are concerned, and presumptuous as regards the lay members of the audience. Superfluous, because four years of association and exchange of ideas should have given the students a fairly complete conception of what cerebration each and every member of the faculty is capable of; and presumptuous because a mere doctor of medicine, for perhaps the first, and possibly the only time in his life, essays the role of a public speaker, before an audience composed largely of the laity.

With some persistence, I have fought this custom which is a relic of the good old times when the chairs in medical schools were held by orators rather than by teachers, and have resolutely refused to do my part toward perpetuating the anachronism. It has at times occurred to me that I might possibly do most for the cause by offering myself as a sacrifice, giving a clinical demonstration, so to speak, of the correctness of my attitude—at least so far as concerned by own individual case. This hope, and

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the very special interest I have in this class, determined me in bowing to the will of the faculty in my assignment to duty tonight. This introduction must not be taken as an expression of any lack of appreciation of the honor of being allowed to appear before an audience representing so much culture and scientific attainment; but as an apology for and explanation of my appearance in a role for which I feel very keenly my lack of training and natural adaptation.

In my remarks I shall violate many, if not all of the precedents established for such occasions. For instance, it is not my intention to attempt to lay down for you, young men, rules for the guidance of your private and professional lives that will inevitably lead to your establishment on a pinnacle of social and professional glory. The pronouncement of high sounding platitudes that reverberate all the more impressively because of their emptiness, and the reciting of axioms of moral conduct would do small credit by inference to the training you have received at home and at college. Your minds are trained and your characters are, for the most part, already formed; and it isn't just or reasonable to suppose that you require any illumination as to what correct principles are, or as to the satisfaction to be gained by living up to them.

Far be it from my purpose to enumerate to you the many qualities supposed to be necessary in a doctor for the establishment of even a remunerative practice, which is as far as most of us can hope to go. Medicine is at one time the most difficult and the easiest calling to make a moderate success of. The most difficult because sheer ability—unless it amount to genius—is helpless without certain social and business qualifications, not the least important of which is a knowledge of how to whisper your name into the receiver of Fame's graphophone, so that your voice will not be recognized when the record is reproduced for the enlightenment and entertainment of the public.

The easiest, for one with the proper business and social qualifications, because veiled in a so-called learned tongue, which is too often a barbarous mixture of Greek and Latin, it is shrouded in mystery to the public and has been known to serve as a satis-

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factory cloak for the densest ignorance. The public is especially weak in its judgment of doctors from the standpoint of professional capacity, and something more than professional capacity will be required of you unless, as already stated, it amounts to genius.

The task of directing you in finding the happy medium between a devotion to the literature of the profession that will make you familiar with the best that is being thought and done by its members, and a devotion to the enlargement of your circle of friends and acquaintances, that will get the quickest results in the way of practice, is a responsibility too great for me to assume. Nor would I presume to teach you how to avoid both the modesty that seeks to hide its worth and the unblushing effrontery that discourses on the street car, and in the barber shop perhaps, upon its list of major surgical operations without a death.

I am no such skilled mariner that I can direct you how to steer between the Scylla of excessive modesty and the Charybdis of blatant egotism and bad taste. Without attempting then, to put the finishing touch with one stroke on your characters, or to point you to the "corduroy" road to financial success, I shall take up for brief consideration a question of a professional nature, and yet not too technical, I hope, for presentation to this audience.

Why is it that a profession claiming a willingness to use every rational means for the cure of disease falls so far short of convincing the public of the truthfulness of its claim, that a myriad forms of specialism—all more or less fraudulent—thrive in opposition to it? The explanation does not lie altogether in the statement that the public likes to be humbugged, nor in the fact that a drowning man will catch at a straw. My belief is that the medical profession itself is largely responsible for this state of affairs, and that our efforts to correct it should be mainly directed toward cleaning our own Augean stables, and that by the time this task is accomplished, we will find little need for urging upon legislative bodies the necessity for protecting sick people against their craving for being humbugged. This question has been so actively agitated during the last few years that most of us have given the matter some thought, and I wish to

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present to you, with all humility, my views upon some of our contributions to this condition, and how we, as a profession, can best aid in correcting it.

The most serious charge to be brought against us is that of ignorance. Anything like an adequate knowledge of medicine today requires more than an average mind, and that that mind should have the advantage of a preliminary education before the study of medicine is taken up. The medical education, which must be thorough, should be looked upon merely as a foundation upon which to build by study, while in active practice. In the past at least, an appalling percentage of doctors have failed in every one of these particulars. They lacked the necessary grey matter; they lacked the preliminary education; they lacked a satisfactory medical education; and they stopped studying the moment they were licensed to practice medicine. Lacking knowledge, they took refuge in the mystery in which medicine is enshrouded to the laity; and as prescribing was easy they perpetuated the drug fetich. Two of the most effective supports to the hands of the irregular practitioner of the healing art were constructed by the doctors themselves. They are, a widespread belief in the mysterious nature of disease and its cure; and an unbounded faith in the efficacy of drugs, if only the proper drug can be found for the given case.

These are beliefs held over from the past, when indeed, the very elect in medicine knew no better. Today the *doctor* knows better, or at least has an opportunity to learn better. In some institutions the proper men are being selected for the study of medicine, and they are being given the proper foundation upon which to build. The reaction against the old-time practice of drugging has gone to the point where it is claimed that materia medica is sadly neglected in the present day curriculum. Be that as it may, your degree of doctor of medicine is not synonymous with doctor of drugs. With all due respect for our medical ancestors, I have never believed that any man had the genius to intelligently prescribe the combinations they were in the habit of using. Upon the graduates of today, who are free from the ignorance and superstitions of the past, devolves the duty of

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placing medicine in the plain sunlight, where it belongs, so the public can understand its real value, and have a point of view from which to make observations upon the self-styled wonder workers. And, by the way, the irregulars are not the only wonder workers.

We are all familiar with the doctor who comes upon the scene just in time to save the patient from a *threatened* attack of appendicitis or typhoid fever, or pneumonia, whose every serious case is desperate, and is only carried to a successful termination by consummate skill. We are likewise familiar with the surgeon, who always operates in the very nick of time, and in whose hands the ordinary surgical procedure becomes a master-piece of skillful technic. No wonder the public gets confused, and being fed daily on miracles by the very people they have been taught to believe conservative, readily find faith in miracles, boldly claimed in plain print, and vouched for by statesman, naval heroes, and, save-the-mark, doctors of divinity, and even doctors of medicine.

It is our duty to ourselves, our profession and the public to be above such stage effects. We must demonstrate to the public that the correct teaching and practice of medicine is alone the lines of plain common sense, and that so far as drugs are concerned, with two or three exceptions, they exert no specific curative action upon disease, but are used almost entirely for the control of symptoms.

We must throw aside some of our ponderous dignity, our bad Latin and worse Greek, and speaking with simplicity and truthfuless the best and plainest English we can, show that medicine today is upon a solid foundation of accurate knowledge of the specific causes of disease, and the changes occurring in the tissues of the human body as the result of disease. The man who really knows medicine can use the English language to express his knowledge, and the doctor who uses technical terms is usually in the language of a distinguished colleague of mine—trying to "obfuscate the mental horizon" of his hearers with what he hopes will be mistaken for the dust of learning.

Simplicity is the hall-mark of true greatness in medicine, as everywhere else. This mark our profession has not always carried in the past. Let us do our small part toward hastening

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the day when the doctor shall not only know his business, but it shall be considered beneath his dignity to cater to the public appetite for the mysterious and the spectacular.

Another condition that makes us vulnerable is that we are a house divided against itself. We are today too distinctly divided into surgeons and internists, or as they are usually designated, general practitioners. Where circumstances permit, it is certainly best from all points of view for a man to limit his practice, never his study, to either internal medicine or surgery; or even to one of the sub-divisions of either. But, after selecting his work, he must not become so narrow (or should I say broad?) that every case he sees comes within the sphere of his action. A familiar character is the surgeon to whom every case is an operative one; and still another, is the internist who will only appeal to "the knife" (Right here I hope I may be pardoned for digressing a moment, to protest to the lay members of the audience against the use of the term "the knife" as descriptive of surgery. It is certainly expressive; it expresses and emphasizes all the horror that surgery contains, and I am afraid it is frequently used to emphasize that horror. However, it is unjust and inexact. In most surgical operations the knife is little used; neither is the knife used anything like a carving knife, nor is it essential that a surgeon should be able to carve a turkey skilfully. Surgery is not a process of carving slices off the human body. So far is this from the truth, that I may say that skill, in the use of "the knife," or even in the use of instruments generally, is not by any means the most important attribute of a surgeon. A skilful operator is not necessarily a good surgeon, and a great surgeon may be a poor operator.), as a last resort, and when too often nature has lost her power of resistance. The surgeon and the internist when both are men of character, skill and judgment, should approach every case from the same point of view. Not that we can ever hope to have doctors always agree—that would indicate that the millenium was at hand—and I for one am in no hurry to precipitate that event—but there is no more reason for a surgeon and an internist disagreeing about a given case than there would be for two surgeons to disagree about it, or for two internists.

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It is high time for us to convince the public that the surgeon is not a man who believes only in operative treatment, and that the internist is not one who doesn't believe in it at all, but that the surgeon is one who only *treats* such cases as require operative treatment, while the internist *treats* none that do require it. For us to prove these facts to the public, they must first be facts. Upon you, who will either select or drift into internal medicine, will fall the difficult duty of assuming a fair attitude toward a competitive science, for surgery has grown and fattened at the expense of internal medicine. You are the men who will be put to the test, for in your capacity of family physician, you will usually have control of the situation. I will not insult you by urging you not to let mercenary motives influence your attitude. The attempt to avoid this feature of the case by dividing the surgical fee between the surgeon and the family physician—which has attained such vogue in some quarters—can only be justified when the patient is aware of the arrangement, and has the disadvantage of converting some weak characters into veritableNimrods, who scour the woods in search of surgical game which they retail to the highest bidders among surgeons of like character. Yours too is the task of going against public prejudice, which is as yet strong against surgery. A death from surgery hurts the family physician who advises the operation as much as it does the surgeon who does it. You then, must at times rise superior to a natural fear of loss of prestige, pecuniary loss, and of public prejudice, with no reward beyond the satisfaction of knowing that you have acted solely in the best interest of your patient. Of whom would so much be expected except of the highest type of doctor?

In order for you to rise to the demands of such occasions you must not have only character, but knowledge. You must be sure of your ground, and to be sure of that, you must have as intimate a knowledge of the surgical diseases, the indications for surgical treatment, and the general principles that underlie surgery as a surgeon himself. The technique alone is unessential. It is only in this way that you can meet the surgical consultant on an equal footing, work in harmony with the real surgeon, and

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protect your patients from the mere cutter with a fever for operating.

Once more I crave the privilege of digressing to warn my lay auditors against a prejudice that has a very deleterious effect on present day surgery. This is the feeling that the surgeon must have something to show when the operation is over. "Did you get the appendix, doctor?" "Did you find the bullet?" "How many gall stones did you remove?" What matters it if you did stop a spreading peritonitis, if you failed to get the appendix? What matters it if you successfully removed several feet of lacerated intestine, or stopped profuse hemorrhage from the liver, if you didn't find the bullet? What matters it if you drained a gall bladder on the point of rupture from distention with pus, if you failed to get the stone lodged deep down in the cystic duct? The operation is a failure, though the patient gets well.

The companion statement to this, and the one usually made is, "the operation was a success, but the patient died." This statement is often used now-a-days by misguided people in an awkward attempt at being funny. But too often it is seriously meant. How absurd, and more, how pitiful! For this feeling in the laity is responsible for a tremendous amount of meddlesome surgery. So long as the public judges the skill of a surgeon by the length of the appendix, or the number of gall stones he removes, just so long will many operators persist in their efforts to obtain the brush as an evidence of their ability to lead the hunt.

There is one more point upon which I wish to touch just for a moment. Our attitude toward irregularity of every description has been too combative. Fighting any proposition merely advertises it, draw upon the assailants the suspicion of selfishness, and blinds them to any good it may contain. Our attitude should be interested and coolly judicial toward every means brought forward for the cure of disease, and we should never be provoked into a loss of temper by even the most arrant fraud, for we lose at least our dignity and gain nothing.

The lending of your efforts to the correction of these errors that I have indistinctly outlined, may not prove the most lucrative line of conduct. In fact, I like to avoid any reference to the

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practice of medicine as a mere means of making money. But I feel that if this line of conduct is followed, your lives will accomplish much for the credit of our profession, and both directly and indirectly for the good of mankind.

And now in conclusion I wish you one and all God-speed. In an institution like this, where teachers and students are brought so intimately into contact, the growth of a mutual interest and affection is but natural. For you, as a class and individually, we have the warmest affection, and we hope that the future holds for you all the good things of life. Personally I feel tonight that I am losing in this class a friend, and though to you this is an occasion of unalloyed pleasure, to me it is not without its element of sadness. May God bless you and prosper you!

OBSTETRICS.

BY E. S. MC KEE, M.D., CINCINNATI.

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THE PASSAGE OF ANAESTHETICS FROM MOTHER TO FETUS AND SUCKLING.

A discussion on this subject recently took place at a meeting of the Societe d'Obstetrique de Paris (*L' Obstetrique,* Nov. 1906), M. Nicloux, as the result of numerous experiences on guinea-pigs, found that chloroform travels freely from the mother to the fetus. Indeed, he discovered that the liver of the fetus held more than was to be detected in the liver of the mother. This phenomenon was attributed to the fact that the fetal hepatic tissue held more lecithin, but M. Nicloux asked for further evidence from chemical research. The natural diffusibility of chloroform readily accounted for its rapid passage into the fetal blood and tissues. Turning to the influence of chloroform on milk, M. Nicloux examined the blood and milk of goats and noted that the anæsthe-

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tic may be found in a higher proportion in the milk than in the blood. This fact is chemically quiet explicable, as chloroform has a strong affinity for fats. M. Nicloux detected about 10 mg. of chloroform to 100 grams of human milk in two patients under his personal observation. M. Dudin believed that whatever might be the chemical proportions of chloroform in the fetus and in human milk, clinical experience showed that the matter was of little importance. He and M. Serret published some researches five years ago relative to the use of the curette in the puerperium. The patients were put under chloroform, but the infants which they suckled were quite unaffected. Badin, however, advised Nicloux to continue his researches. M. Schwab reported a case where a woman was kept under ether during an obstetrical operation. The child when delivered required insufflation. Then as the respiratory movements set in the expired air smelt very strongly of ether. M. Tissier had turned his attention to the question, and had found that the fetus and the suckling suffered but little if at all from chloroform administered to the mother or nurse. He appeared to think that owing to its diffusibility, although it readily entered the fetus, it was rapidly eliminated; yet whilst giving his opinion that Nicloux's researches proved that the anæsthetic did little harm in the fetal liver, it might enter the heart and arterial circulation and fix on nerve elements. Thus all agreed that the danger of even temporary disturbance of the fetal and infantile economy when the mother or nurse took an anæsthetic was trifling; no clear distinction between ether and chloroform was drawn, but only M. Schwab spoke of experiences with the former anæsthetic.

Teratoma—Malignant Dermoid.

Rosenstein (Zentrbl. f Gynakol. 1906) observed this grave condition in a woman, aged 22, the mother of two children, of which the youngest was over a year old; menstruation was regular. She has complained of mucous discharge for five months and noticed that it had become sanious. Pains of the labor type ultimately set in and emaciation become marked, the temperature rose to over 101. A soft round tumor of the size of a man's

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head occupied the middle of the abdomen. It appeared to be an enlarged uterus, and not until anæsthesia was given was it found that the uterus was small and perfectly separate. At the operation a great quantity of bloody serum was found in the peritoneal cavity. The tumour, which had developed in the left ovary, was universally adherent. It was mostly solid, made up of tissues from all the three germinal layers, mixed up in the usual anomalous manner. There was one cystic cavity with incisors, premolars and hair springing from its inner wall. At the end of three weeks the patient left hospital in good condition, but distinct resistance could be felt on the right side of the uterus. Two months later the patient returned extremely cachectic, with severe ascites and a tumour as big as that which had already been removed. She refused any further operation. Schiller, in a discussions on Rosenstein's case observed that he had removed a teratoma from a girl aged 14, the operation was easy but recurrence very rapid. (Herbet Williamson publishes an original report of a similar case in a girl, aged 16, in Allbutt and Playfair's System of Gynecology, second edition, 1906, p. 453.)

Ectopic Coexisting With Uterine Pregnancy.

Dr. Doaldson (*Brit. Med Jour.*, Feb. 23, '07) describes a case of ectopic pregnancy coexisting with uterine pregnancy in a woman aged 40, four para. Previous to this pregnancy menstruation had been regular every four weeks, lasting one to fourteen days. She was delivered of a seven-months living child eight weeks prior to admission to hospital. Three days after the confinement her doctor noticed an abdominal swelling which increased in size and was accompanied by intermittent cutting pain in the left side. During the periods lasting seven and fourteen days respectively, the latter accompanied by the passage of two large, stringy lumps. There were no symptoms of severe pain, fainting, or other signs of hæmorrhage. An irregular swelling occupied the hypogastric and both iliac regions, and her vagina was found to be distinct from the uterus. Abdominal section revealed a sac composed of the left Fallopian tube containing a decomposed fetus measuring 13 inches and weighing nearly

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three pounds. The sac was adherent to intestine, and was therefore stitched to the edges of the abdominal wound and packed with gauze. The patient was discharged convalescent at the end of six weeks. The extrauterine was probably synchronous with the uterine pregnancy, death of the fetus occurring when the uterine fetus was born.

Fatal Vomiting in Pregnancy.

Dr. Stokes (*Brit. Med Jour.*, Feb. 23, '07) also described a case of fatal vomiting in a woman, 2 para, who was seven months pregnant. From the second to the sixth month the vomiting was not excessive, but for the forthnight preceding admission to hospital it was continuous and "coffee-ground" in character. She was so ill that induction of premature labor was deemed inadvisable. Rectal salines were administered. Death occurred on the second day after admission, from cardiac failure. At the autopsy partly-digested blood was found in the stomach and small intestine; the kidneys were congested; the other organs were normal.

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Selected Articles

Further Observations on Epiphyseal Separation of the Humerus.

BY M. M. LUCID, M. D., CORTLAND, N. Y.

The subject which by your courtesy I am at liberty to introduce for discussion today is one which is full of interest and considered important alike to physician and surgeon. It has been selected by me not alone because of the paucity of research upon the conditions of which I desire to make mention, but because my attention has been attracted recently by some very unique and interesting cases and, too, because the scope of usefulness of surgical methods and appliances is continually changing and occupies the foremost place in the work, the thoughts, and the discussions of practical surgeons.

ANATOMICAL PHASES.

I shall discuss only the practical anatomical phases, the etiology, diagnosis, and treatment equitably, for the purpose of reviewing such conclusions as have seemed justifiable, with the hope that I may be able to present an outline of this subject which will prove of interest, and invite your criticism.

It is, indeed, strange that so little has been written upon the subject of epiphyseal separation of the ends of the humerus, either by remote or modern surgeons; but the epiphyseal structures are small, and we are never conscious of the fact that nowadays most surgeons are looking for larger game. The subject of epiphyseal separations is still in need of further study, and the knowledge necessary to insure positive results can only be gained by the careful study of many cases. Nothing systematic save the brief references extended by Hamilton, Smith, and Moore, and recently by Poland, has, to the writer's knowledge, been published regarding epiphyseal separation of the ends of the humerus.

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When we appreciate the positive fact that no physician or surgeon has, after improper reduction and faulty fixation of the injury referred to, had perfect movement, we have sufficient data to justify us in concluding that in no field of bone surgery is harmonious action of the physician and surgeon more necessary for the results demanded and justly due the suffering patient.

Many are the problems that present themselves for solution in the management of cases of epiphyseal separation of the ends of the humerus, for the proper determination of which all of the surgeons resources are requisite. Few cases in bone surgery make greater demands upon his tact, knowledge, experience, and judgment; or in which the necessity for intelligent and effective treatment is more urgent.

While it is not the purpose of this paper to give a detailed report of my series of cases, six of the upper and nine of the lower, in all fifteen, still I find upon consulting the literature of the subject that it is sufficiently rare to demand your attention, and from such references I feel that we can draw valuable deductions when associated with similar experiences which, no doubt, many of you have had.

A brief description of the plan of development of the humerus will enable us better to understand the separation of the epiphyses, both at the upper and lower ends of the bone. The humerus is developed or originally formed from seven cartilaginous centers —namely, one for the shaft, one for the head, one for the tuberosity, one for each epicondyle and two for the lower articulating ends of the bone. The shaft is ossified in nearly its whole length at the time of birth. Ossification begins in the centers for the upper end of the bone between the first and fourth years, and they coalesce by the end of the fifth year so as to form a single epiphysis, which finally unites with the shaft about the twentieth year of life.

At the lower end of the bone, ossification begins in the radial portion of the articular surface at the end of the second year, and the trochlear portion at the twelfth year; in the internal epicondyle at the fifth year, and in the external epicondyle at the fourteenth year. At the sixteenth or seventeenth year of life all

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the centers are joined to each other and to the shaft, except the inner epicondyle, which does not unite by bone with the shaft till the eighteenth year. It will be observed, therefore, that although the ossification begins in the upper epiphysis first, it is the last to form bony union with the shaft, which process is completed about the twenty-first year of life. It is hence apparent that the superior epiphysis of the humerus comprises not only the head of the bone, but likewise both tuberosities, with that portion of the bicipital groove which is not situated between the processes. Internally, it corresponds exactly to the cartilaginous surfaces of the head of the humerus, but in front, externally, and behind its line of junction with the shaft passes below the tuberosities. The supraspinatus and infraspinatus muscles are not therefore, attached to the lower fragment, nor is there any difficulty in comprehending osseous union, for the head of the bone forms one body with the tuberosities, and is richly supplied with blood.

ETIOLOGY.

Epiphyseal separation of the ends of the humerus belongs almost exclusively to the periods of youth and childhood, and is occasioned either by a direct blow or fall upon the shoulder, or by a violent wrenching of the arm, as during delivery, causing separation of the superior epiphysis; while separation of the lower epiphysis is usually the result of a fall upon the elbow, excessive abduction or abduction of the forearm with superextension, or a sudden or unexpected push of the arm which it is unprepared to resist.

PATHOLOGY.

Upon dissection in these cases in the young, the head of the humerus is found broken off at the tubercles, but it remains in the glenoid cavity and does not move with the shaft. The upper end of the lower fragment projects in front, when displacement exists, and is less sharp and angular than in cases of a broken bone. Taking the head of the humerus of a subject ten years of age, parted by maceration we find the angle made by the junction of the plane projected through the anatomical neck which

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makes about two-fifths of the whole surface, with the plane passing below the tuberosities measures about one hundred degrees.

Separation of the upper epiphysis of the humerus will not necessarily open the shoulder joint, unless in cases of very great violence, as the capsule is firmly attached to the diaphysis. In the adult the epiphyseal line marks the upper limit of the surgical neck.

The muscles are apt to acquire their greatest tension at the moment of separation, and those whose actions are in direction with the shaft press upward, the head being set upon the shaft at an angle, and were it not for the muscles attached to the tuberosities, those which act in the direction of the shaft would have a tendency to roll the now movable head upon the glenoid surface; but, instead, the muscles attached to the tubercles contract and roll the head in the socket and produce dislocation backward of the facets, which position throws now the superior edge of the diaphysis forward and retains it there. When extension is made, the head works on the projecting angle of the diaphysis, and the tense deltoid muscle, pressing the shaft backward, will restore the rotundity of the shoulder; but the cessation of the extension finds the capsular muscles ready to roll the head out and project the diaphysis forward, and the symptoms return as soon as the extension ceases.

Of the lower epiphysis very little has yet been written concerning the pathology. The synovial membrane forms at about the fifteenth year afterwards, when it overlaps the epiphyseal line. The epiphyseal line is a little higher on the outer than on the inner side. It inclines obliquely downward and inward. The epiphysis is thinner internally than externally. The humerus is separated from its cartilaginous expansion at the condyles near the elbow joint, in which case the lower fragment would comprise the entire epiphysis, which is composed of four distinct pieces, but either or both epicondyles may remain attached to the fragment.

DIAGNOSIS.

Notwithstanding the very positive statements with reference to the diagnosis of epiphyseal separation of the ends of the

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humerus by Sir Astley Cooper, Professor R. W. Smith, and Professor Frank H. Hamilton ,one would scarcely suppose that great confusion had existed, and still exists, as regards the exact nature of fracture of the humerus at the point under discussion; but error of diagnosis does occur, and that constantly, as pointed out by Poland in his work upon "Separation of the Epiphyses." In my opinion this results from the fact that a clear conception of the change of position has not been put forth, and more than this, no method that secures reduction, save that of Moore's which is a most effectual one, has thus far been proposed. The constancy of the symptoms make this condition differ from most that occur in adjoining structures.

The chief diagnostic signs of separation of the upper epiphysis from the humerus are: first, an abrupt projection can be seen and felt on the front of the shoulder about one inch beneath the coracoid process, caused by the upper end of the lower fragment. Second, crepitus, when felt, is of a softer character than in fracture. Third, the end of the shaft is rounded and smooth, not sharp as in fracture, and has the form of a low cone. Fourth, the immediate recurrence of the deformity when the means employed for its reduction cease to be in operation. The most important practical point with reference to the diagnosis is that the accident is apt to be followed by arrest of development if not properly reduced. These diagnostic and unfailing manifestations deserve to be memorized, because they exemplify the great difficulty often experienced in diagnosticating exactly the true seat of the solution of continuity, as well as the necessity that these signs should be correctly interpreted. The x-ray affords, perhaps, the most positive means for diagnosis. The simple anatomical fact which affords valuable information with reference to the diagnosis of separation of the upper epiphysis is that the tuberosities of the humerus form a part of the upper fragment.

TREATMENT.

In view of such a displacement at the upper end of the humerus, the natural mode of reduction would seem to be one that would carry the shaft backward and thus restore the corresponding

facets to their normal positions. The great error that is constantly made is the severe and protracted extension made to reduce the relaxation, which traction may, in a measure, cause the disappearance of the deformity; but the moment the parts are abandoned to the uncontrollable action of the muscles the deformity recurs.

The most effectual mode of reduction is by carrying, with moderate extension, the humerus forward and upward. The head will roll upon the glenoid surface in any motion of the arm until restrained by its capsule. Now then, while the humerus is still back of the central line of the body, the head is rolled upward, and long before the humerus is brought up perpendicularly, the capsule at the lower border of the head has become tense, thus holding it firm; while the humerus, being thrown up and restrained by its muscles, slides the diaphysis backward, producing a coaptation of the corresponding facets. In other words, the reduction is effected by carrying the arm forward and upward, using moderate extension to the perpendicular line with the body.

The retention is effected by moderate extension while bringing the arm down to the side, and maintaining this slight extension until dressing for the purpose of continuing it are applied. Moore's method, which consists of a Swinburn splint fastened to the outer side of the arm, resting its lower end in a strip of adhesive plaster, while the upper end projects two inches above the shoulder, with a notch through which a bandage is passed under the axilla for extension, fulfills easily and promptly the indications.

With reference to the diagnosis of separation of the epiphysis at the lower end of the humerus, it is easy—on paper. But when the surgeon is called, enough time has usually elapsed to permit of swelling, and with an elbow-joint often as big as the calf of the leg, or bigger, and the bony landmarks covered deeply by congested and edematous flesh, I know of nothing more difficult, in reality, than to determine just the nature of the injury. The x-ray affords at this juncture valuable assistance.

There may be fracture alone of the humerus, ulna, or radius,

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or any two of these bones, or each may have therewith associated a dislocation, or a dislocation alone may be present. The dislocation is easiest of diagnosis because of abnormal rigidity, but fractures, either singly or with a dislocation, are less easily determined with exactitude. If the beginner in surgery will wrap the elbow of a skeleton in a pillow and try and examine the joint through its depths, he will approximate the difficulty of the case. Could we be sure of dislocation only, our duty is plain—namely, simply to reduce it at once, for any delay increases the difficulty and also invites a stiff joint. Again, if we felt certain of fracture alone, we should feel mentally at ease, for there need be no haste in setting a fracture if the fragments are not badly displaced, because no callus is formed for nearly a week, which time would be sufficient to allow swelling to subside, and reduction could then be exactly performed.

Unfortunately, however, the surgeon must often be in doubt, because of great swelling, as to the exact diagnosis, and a positive diagnosis obtained at the earliest possible moment has everything to do with good surgery. In this condition also the x-ray affords valuable and most reliable aid in early diagnosis. Under such circumstances, the practical point I am about to mention becomes of the utmost value. Put your patient under anesthesia, this being the proper procedure in all cases of fracture, unless there is some organic lesion. Now, apply an Esmarch bandage, starting at the hand and going very slowly but firmly up the forearm, over the swollen elbow joint, and continue until the armpit is reached. Leave the bandage on say for ten or twelve minutes. At the end of that time, remove it, beginning at the hand, but leaving the final few turns upon the upper end still tightly in situ. The elbow thus exposed will be pale, bloodless, and no longer swollen. All the congestion and edema are, for the time being, caused to vanish.

The diagnosis can now be made with positive ease upon the following points: the lower end of the upper fragment will be tilted forward, will be prominent, and the elbow joint pushed seemingly backward with limited flexion, but not extension of the forearm. The lower end of the upper fragment has greater

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width than any fracture at the base of the condyle and the line of separation is nearer the end of the bone. There is no change in the relation of the three bony points. The existence of abnormal mobility at a very low level in the humeral shaft, muffled crepitus, is very suggestive.

REDUCTION.

An easy mode of reduction is to grasp the forearm and make extension with the knee in the bend of the elbow, adjusting the fragments with the free hand. Now the remaining turns of the Esmarch bandage are removed, and, of course, the swelling promptly returns; but the surgeon has accomplished his purpose. He knows the real diagnosis, applies both an anterior and posterior angular splint, with pressure anteriorly over the seat of separation, is ready to protect his own reputation, and can forecast the outcome with some degree of accuracy.

We all know that it is early errors in exact diagnosis, with resulting unfortunate lines of treatment, which most often subject the practitioner to unfavorable results. The question of passive motion in this separation is absolutely essential to get perfect extension and flexion. This should be resorted to by the surgeon—no one else— about the seventh or eighth day; then about the twelfth day, and after that every other day until the twentieth day. The fragments should be held in apposition and motion given very cautiously, thus permitting a thorough understanding as to what is taking place at the seat of the separation. If after the twenty-second day complete flexion and extension cannot be produced, an anesthetic should be given and the adhesions broken up so as to allow both flexion and extension. Many times it is advisable, after provisional callus formation when the fragments are in apposition, to bandage the arm one day extended and the next day flexed. In this manner brilliant and satisfactory results may be obtained when other methods might result in ankylosis.

I am very glad to have had the opportunity to present this subject. There is no branch of surgery that is more interesting, and I know of none in the practice of which ingenuity, conservatism, and good judgment are more essential to the securing of good results.—*Buffalo Medical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

The Surgical Treatment of Carbuncle.

The local treatment of carbuncle resolves itself into a vigorous fight against a virulent infection, pyogenic and pathogenic in character, and so pent-up in the deeper structures of the skin, with continuous spreading and sloughing, that access to the infection by either medication or knife is difficult.

It is advisable, whatever treatment is to be pursued, to give the patient an anesthetic, preferably gas. The patient being asleep the skin is rendered aseptic rapidly, first with ether, which dissolves the fat and exposes the germs, and second, with Harrington's solution, which is kept in contact with the carbuncle and surrounding skin at least two minutes.

If the carbuncle is situated on the extremities or on the body of the patient, excision is the treatment *par excellence.* A circular incision, half an inch to an inch away from the infected area, extending deeply and including the subcutaneous fat, will get rid of the carbuncle with "one fell swoop." In four out of seven carbuncles treated this way, primary union was obtained.

Carbuncle on the neck and face, especially on the lips, is frequently so extensive that excision is impracticable. In such cases the carbuncle must be drained by free incisions; if not very extensive, by a simple crucial incision. In making incisions care must be taken not to infect the surrounding healthy structures with the knife. The incision should be made from the non-infected skin to the center of the carbuncle with an aseptic knife. A second knife is used to cut through the opposite border in a similar manner. A new, clean knife should be used for each incision. A simple crucial incision is usually insufficient, for the brawny, infected border will be left undrained and deep infection usually takes place. Harrington's solution is poured into the incision and then washed off with normal salt-solution, after which an antiseptic compress is applied and left undisturbed for six hours.

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By this time the oozing of blood has ceased and a persistent course of cleansing of the wound is undertaken. For three days the wound should be cleansed every three or four hours with antiseptics. Gauze soaked in a 10 per cent solution of iodoform in glycerin furnishes an efficient and suitable packing for such a wound; it is easy of application and does not hurt the patient when it is removed. When improvement in the wound is noticed, the time between the dressings can be lengthened until eventually it is only dressed once a day or every other day.—*The Medical Mirror.*

Fracture Dislocation of the Spine.

Samuel Lloyd says that 60 per cent of fractures of the spine are fracture dislocations; 20 per cent are simple fractures; 20 per cent are simple dislocations. Fracture of the sternum lead to a suspicion of injury to the vertebral column. Simple fractures of the posterior portion of the spine generally involve the laminæ and compressing bone should be removed. When the spinal cord is not injured, operation is not indicated unless spinal cord symptoms come on, due to later compression. The symptoms are those of simple fracture combined with others that are characteristic. The patient cannot walk, there is marked shock, tenderness over the spine, localized pain, with or without irregularity of the spine. The author does not favor the application of a plaster jacket, but advises that the patient be placed in a horizontal position on a springless bed, with extension and counter extension, unless the fragments are very movable, or pressure symptoms come on. When the spinal cord is completely crushed there is immediate relaxed motor paralysis, involving the parts below the lesion, and absence of rigidity and spasm. Partial injury is indicated by slower onset of paralysis, unilateral or irregular distribution of it, comparative preservation of reflexes, and rapid improvement. The area of anesthesia is sharply marked and at a level corresponding to the segment of the cord that is crushed and this is materially below the seat of fracture. Above this is a strip of hyperesthesia, pointing to irritation of nerve roots, and below this a strip of ther-

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mal anesthesia and analgesia. Incomplete anesthesia points to incomplete lesion of the cord. The author favors waiting before operating, until shock is recovered from, and operating as soon as symptoms of compression are evident. When we feel sure that the cord is not crushed we may operate, early if there is no improvement, later as soon as there is evidence of compression from clot, inflammatory thickening, or callus, improvement having at first occurred. In general it seems best to give the patient the benefit of the doubt by operating, and do so earlier than is usually done. It is not probable that any true regeneration of the cord occurs when it has been crushed but that some uninjured, or partially injured, fibers that are left undergo repair and take up function to a certain extent.—*Medical Record.*

Shock with Abdominal Pain.

Very often in abdominal disease and acute trauma the patient's mind becomes dulled: apathy—and later unconsciousness—appears; urine excretion is diminished or absent, the pulse and respiration become imperceptible, temperature subnormal, pupils dilated, slowly responsive or fixed, and death occurs speedily, in the severe types of disease or injury. Vomiting is frequently prominent, but comes from acute sepsis, not peritonitis. A death of this kind very soon after an injury or rupture of an abscess may usually be said to be due to shock; but if death be delayed more than a few hours it is from acute sepsis. "Deferred" or "delayed" shock is sepsis, pure and simple. But there is a true shock associated with acute pain. Severe traumatism (especially if productive of sudden, complete rupture of liver or spleen or perforation of bowel, acute pancreatitis; sudden complete blocking of the ureter, the biliary passages, or even the pancreatic duct; mesenteric embolism; sudden strangulation of the gut or even omentum by constriction of a hernia or twist; torsion of the pedicle of an ovarian or uterine tumor—all these are always more intensely shocking than the same lesions when slowly produced, and are always accompanied by much suffering. From this kind of shock the temperature slowly rises, often going to 100; but the

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chief guide is the pulse. A progressive, even slight, hurrying and weakening of the pulse, with or without persistent lowering of body temperature, is indicative either of persistence of the exciting cause, the superaddition of more or less sepsis or of gangrene; and, especially, if accompanied by cessation of pain, may be regarded as a pretty indication for immediate operation.

—*American Journal of Clinical Medicine.*

Thyroid Grafting (Myxedema and Pregnancy).

The patient was a young woman upon whom a total extirpation of the thyroid gland had been performed. As a result of this operation, she had been obliged for years to consume large daily quantities of thyroid gland substance. The following procedure was decided upon and adopted: In the course of two sessions, with three and a half months' interval the authors implanted 38 small pieces of human thyroid gland, in various localities, underneath the skin. The resulting improvement, which has persisted since the time of the operation two years ago, was expressed by a considerably slighter need of thyroid gland preparations. It is especially noteworthy that the patient not only became pregnant, but that during this pregnancy swelling was observed to occur at some of the points of implantation, such as is not uncommonly noted at the thyroid gland during normal pregnancy in healthy women. These thickenings subsided and disappeared atfer the birth of the infant.—*The Post-Graduate.*

Nasal Tamponing in Nosebleed.

The author, in protesting against the widespread employment of nasal tampons in the treatment of nosebleed, either of accidental or of operative causation, says he has obtained much better results from the application of a mixture of one part of perhydrol and nine parts of water. Nasal tampons not only close up the air passages, but in many instances, when infectious foci are present in the nose, pus may be forced into the adjacent sinues and thus give rise to severe complications. A rapid diminution in caliber

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of the bleeding vessels, such as may be obtained by the use of adrenalin, is not satisfactory, and he believes that the thrombin-like action inducted by perhydrol (hydrogen peroxid Merck, 30 per cent. by weight, 100 per cent. by volume) meets the condition better than any other form of medication.—*Dr. C. Hauselmann* (*Monatssch f. Ohrenheilkunde,* October, 1906).

Appendicitis in Infants and Children.

John F. Erdmann says that the diagnosis is more difficult in children with appendicitus than in adults, on account of the absence of a good history, and the complication with gastrointestinal complaint. He discards the idea that the eating of meats is one cause of appendicitis because he finds appendicitis occurring in milk eating infants. The rapidity of intoxication of the child due to the spreading of the peritoneal invasion, and the marked lessening of resistance in the infant are evident. The appendix has not descended to its normal position until the third or fourth year, and is often found under the costal arch, so that the point of pain and tumor is much higher than in the adult, being located in the loin. There are many gastrointestinal symptoms, the child vomits and the temperature is elevated, while he wards off the examining hand by protecting the abdomen. Rectal palpation and blood examinations give little aid in diagnosis. Concretions have been found by the author in the appendix. Pinworms have also been found in ten cases. Floating kidney has been present in several. The author is a firm believer in early operation, with a small incision. The bowels should move the day after operation. The patient is allowed to roll, and sits up in bed the third or fourth day.—*Medical Record.*

A New Method of Operation for Epispadias.

Carl Beck describes a new operation for epispadias designed to produce a urethral canal that shall be lined with mucous membrane. A case is cited as an example. There was a short penis, with glands, but without any canal, a broad furrow lined with

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mucous membrane being continued to a funnel-shaped orifice in the bladder. He dissected the surrounding walls, including the whole urethral gutter, as a hernial sac is dissected and mobilized in operation for hernia. A continuous incision was made around the funnel and urethral gutter, and a coherent canal shelled out and brought forward to form the new urethra. The glans was perforated with a bistoury, and the canal drawn through the opening and the mucous membrane sutured to the tip of the glans. Now, six months later, the boy retains urine for four hours, can pass water at command, and throws a stream six inches in length.—*Medical Record.*

SURGICAL TREATMENT OF TUBERCULOSIS OF THE KIDNEY.

1. Kelly bases his discussion of the surgical treatment of tuberculosis of the kidney on 57 nephrectomies with 4 deaths, giving a primary mortality of 70 per cent. He makes the following points: (1) Tuberculosis of the kidney, not including general miliary tuberculosis, is always unilateral at the start. (2) It is practically always hematogenous in its origin. (3) Primary tuberculosis of the bladder is rare. (4) Although a bladder tuberculosis cannot heal while there is a tubercular kidney above, it does respond to suitable treatment after a nephrectomy. (5) Nephrectomy is the operation of choice, and the proper time to do it is as soon as possible after the diagnosis has been made. (6) Involvement of the bladder is not a contra-indication to nephrectomy, nor is tuberculosis elsewhere in the body unless extremely active. As regards concomitant involvement of the other kidney, Kelly says that where the worst kidney is not secreting at all or very little, its removal seems to benefit the sounder one and to help the general condition remarkably, though only temporarily. Hyaline casts and albumin in the urine from the second kidney are no contra-indication to nephrectomy. Cases where the ureter can be removed respond more quickly to bladder treatment than do those where it is allowed to remain.

8. In a series of animal experimentations the authors were unable to produce a condition of shock by section or electrical stimu-

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lation of the mesenteric and cœliac ganglia. In the presence of a peritonitis due to moderate doses of turpentine, however, stimulation of the ganglia was regularly followed by marked evidences of collapse and death, either during the experiment or shortly afterward.

10. Reynolds believes that when pregnancy occurs in a neurasthenic woman with little nervous endurance or capacity for bearing pain, with poor muscles, heart muscle and lung capacity, and with ill-trained and usually deficient eliminative system, her habits and general condition should be most carefully regulated during this period. When such an obstetrically weak woman has steadily retrograded during pregnancy the inevitable fatigues of natural labor are more than the disadvantages of operative delivery. He therefore advises that at the calculated date of term or with the advent of the first pains of labor, such cases should be carefully prepared, fully etherized, and either instrumental delivery or Cæsarean section carried out.

12. Meyer presents a valuable colored plate of the skin condition known as akanthosis nigricans which frequently accompanies intra-abdominal carcinoma.

14. Theilhauber concludes a rather scholastic address on versions and flexions of the uterus with the following statement: "Every position of the uterus within the true pelvis is normal: abnormal is the position of the uterus outside of the pelvis—the prolapse of the uterus."—*Boston Medical and Surgical Journal.*

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MEDICAL

Opsonic Therapy.

Charles D. Aaron, in the *N. Y. Medical Journal* for December 1, 1906, reports a clinician's observations of opsonic therapy. According to the revised views which Wright now holds and which came step by step through his use of various bacterial substances in the form of vaccines, opsonin is an ingredient of the blood serum, which aids phagocytosis by its inhibiting action on a given microorganism. That is to say it acts on the microbe, and prepares it to be ingested by the protective body cells or phagocytes, chief among which are the polymorphonuclear leucocytes of the circulating blood. The blood serum of man contains opsonins for various pathogenic bacteria, and in a state of health this opsonic content, or "opsonic index" as it is termed, is at a certain or normal level. Now the opsonic power, or in other words the opsonic index, fluctuates, rises and falls, and during infection by a certain bacterial species the opsonic index for this particular species is usually below normal, or to use one of Wright's phrases, the individual's serum is in a "negative phase" of opsonic power. By his natural recuperative power, that is by his spontaneous active immunity, the infected individual may generate opsonins of sufficiently increased potency to overcome the invading bacteria, and to permit the phagocytes to destroy them, when natural recovery ensues. Similarly by hygienic or therapeutic measures this opsonic activity of the blood serum may be increased. But the chief merit of Wright's work lies in the fact that he succeeds, by the use of his bacterial vaccines, in artificially stimulating the flagging opsonic power of the infected individual's blood, and of arousing it to a point at which healing processes begin and progress to recovery. As prepared at the present time these vaccines are suspensions in sterile normal salt solution of pure cultures of various bacteria grown on the surface of agar only to the height of vegetative activity, and killed by heating for 30 to 60 minutes at 60 degrees C. Practically most striking results are

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attained in cases of acne in which we have to deal, as all are aware, with an invasion of the skin follicles by one or more of the staphylococcus pyogenes group. Cases of long standing, in which all internal and external remedies had been tried in vain by skilled specialists, yielded to inoculation by the appropriate staphylococcus vaccine. In one case of furunculosis of chronic character, of six years duration, staphylococcus vaccine given under guidance of the opsonic index produced complete recovery in two months. Sycosis barbae of an aggravated form treated with epilation and antiseptics for over a year with no benefit, yielded within a week after the second inoculation with staphylococcus vaccine. Equally good results have been obtained in chronic or local infections with the streptococcus, pneumococcus and colon bacillus. Pneumococcus vaccine has been used in chronic empyema following pneumonia with good results, and malignant growths seemed benefited. Many cases of lupus improved and one had all the lesions healed and the patient was marvelously well.—*The Cleveland Medical Journal.*

The Treatment of Arteriosclerosis.

In the treatment of arteriosclerosis, Senator lays much emphasis on the diet, which should consist chiefly of milk, vegetables and fat. Animal proteids and extractives are to be avoided, especially red meat. The reason for this, according to Senator, is that meat increases intestinal putrefaction and therefore the danger of absorption of toxic material. The vegetable diet has yet another advantage, for it decreases the viscosity of the blood, and therefore the work of the heart and arteries. Potassium iodide has the same effect, and is best given as iodipin or sajodin; it can be advantageously combined with one of the nitrites. Hydrotherapy, massage and gymnastics may be of benefit, but must be used with caution owing to the danger of overstraining the heart. Various preparations have lately been put on the market under the name of antisclerosin, regenerol, etc., containing various mineral salts in the proportions in which they occur in normal blood serum. The use of such preparations appears to

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have some justification, for it has been shown that in arteriosclerosis the salts in the blood are diminished.—*Boston Medical and Surgical Journal.*

The Pathogenesis of Colitis in Man and Animals.

Simon Flexner, M. D., and J. Edwin Swet, M. D. (*The Journal of Experimental Medicine,* August, 1906). In this article the authors have recorded their observations upon the toxins of the Shiga and the Flexner bacilli. The dysentery toxin exerts its effects upon the central nervous system and upon the intestine. Sometimes one set of symptoms predominates and sometimes the other, depending upon the resisting power of the individual animal.

In the case of the rabbit it has been conclusively demonstrated that the lesions in the cæcum are caused by the elimination of the toxins of dysentery through the mucous membrane, and not by the contact of the germs of their toxins in the intestinal canal. Whether this is true in man or not has not yet been proven, though analogy certainly bears it out. It is believed that the dysenteric bacilli form their toxin in the small intestine, from this it is absorbed, and is then eliminated again through the mucous membrane of the large bowel. The inflammatory changes take place equally in the mucosa and submucosa, but other pathogenic organisms undoubtedly affect the diseased mucosa and more especially those portions of the transverse folds which project more noticeably into the lumen of the colon.—*The American Practitioner and News.*

Dermatitis Caused by Resorcin.

Resorcin is recommended in almost all dermatoses and in eczema it is employed in solutions of 1-2 to 2 per cent. The author, Dr. Rosenthal (*Annale Syphiligraphie,* Nov., 1906) had ordered wet applications of a one per cent solution of resorcin and a two per cent solution of boric acid for 15 minutes several times daily. These applications having relieved the itching, he had them

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covered with impermeable tissue and left them on for about an hour. This caused a violent dermatitis with severe pains and itching of the whole face and enlargement of the neighboring lymphnodes. Three days later the pruritus became generalized and a papulous rash made its appearance. Still later herpes appeared on the temples. The pruritus lasted for several weeks while the dermatitis was cured rapidly. The urticarial rash must be attributed to the absorption of resorcin, while the herpes was due to an affection of the nerve filaments. Such experiences indicate the need of some caution in employing resorcin.

—*American Journal of Clinical Medicine.*

Buttermilk as an Infant Food.

August Strauch states that buttermilk has been proven to be one of the best dietetic remedies for gastro-intestinal diseases of children, according to the extant medical literature of Germany. Sour buttermilk, however, is not to be administered in its raw primary state, but should be more or less modified. According to Rubinstein's studies, pathogenic bacteria (of diphtheria, typhoid, tuberculosis, *Bacillus pyocyaneus*), as a rule, gradually perish spontaneously in buttermilk. The acidity of the food promotes tryptic digestion. The digestability of the nitrogenous substances of buttermilk lessens the work of the glands of the stomach and intestines. No absolute rules can be formed for the indications for the use of buttermilk.—*Medical Record.*

Treatment of Acute Cardiac Affections in Childhood.

Adolf Baginsky finds that acute cardiac affections occur in children in about two and a half per cent of the patients that are admitted into the Kaiserin Friedrich Hospital of Berlin, not including the cardiac complications of diptheria and scarlet fever. He describes two cases successfully treated by himself. Pericarditis, combined with endocarditis in one case, were not cured by rheumatic remedies or cardiac stimulants, until to them was added the use of iodide of potash internally, and mercurial in-

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unctions externally. These remedies succeeded in removing the bad symptoms in a comparatively short time, and the patients were restored to a fair degree of health. There was a surprisingly rapid absorption of the serous exudate. The author believes that when there is an exaggerated amount of fluid in the pericardium, exploratory puncture and aspiration are useful to relieve pressing dyspnea and heart weakness. Vesicants over the cardiac he believes to be too cruel a measure to use in childen. *Medical Record.*

The Abortive Treatment of Pneumonia.

G. Lenox Curits declares that until recently drugs have been almost the only means available for the treatment of this disease, but now more efficient measures are at hand. The chief of these he believes to be the ozone-producing electric current. The writer then gives a brief outline. He finds ozonation an ideal remedy for all stages and degrees of congestion. The effects of ozonation are both mechanical and chemical. Abnormal accumulations are oxidized and destroyed, and the morbific elements in the blood are dealt with in a similar manner. However, in treating pneumonia the writer does not rely upon any single remedy. A profuse and prolonged sweat often proves beneficial. External heat as a means to this end is to be preferred to drugs. The use of oxygen in the first stage is valuable. Elimination must be looked after. The patient should be well nourished. The writer closes with a plea for preventive medicine.—*Medical Record.*

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OBSTETRICAL

Hernia of Pregnant Uterus.

A case of this kind is reported by Arthur Holmes (*Clinic and Pure Water Journal*), the protrusion occurring through a recently closed abdominal incision. The patient had become pregnant shortly after the operation, and had noticed a lump protruding from the lower part of the abdomen. This after the confinement had almost disappeared. She again became pregnant, the lump steadily increasing, and circular ulcers formed where the clothes and thighs had rubbed. After delivery in November, 1903, the tumor returned, though smaller in size. In December, 1905, she came to the hospital. On examination there was found a tumor springing from the umbilicus and symphysis, which falling forward reached more than half way down the front of the thighs. This proved to be the uterus and the fetal movements were felt. The skin was very thin and large circular ulcers were distributed over its surface. Some of these extended to the uterine muscle. The patient stated positively that she was at full-term and that labor pains were beginning. She delivered herself suddenly without any trouble of a live child, which presented all the appearances of being full-term. Its weight was 3 1-2 pounds, its length 14 inches. The placenta was removed manually on account of hemorrhage. Reduction of the uterus was impossible because of adhesions. The diminutive size of the child was thought to be due to the diminished blood supply, consequent on the abnormal position of the uterus, and the constriction caused by the ring of the sac. Since delivery the tumor is about the size of a man's hand, and the woman goes about her work, apparently in good health.—*American Journal of Clinical Medicine.*

Hysterectomy for Fibroids of the Cervix.

Dr. Haultain has observed 22 cases of fibroids confined to the cervix alone, while in 7 cases both the cervix and corpus uteri were involved, and in one there was a complicating pregnancy.

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In all but one of the cases the tumors were uninodular. The symptoms chiefly resulted from pressure upon the bladder and rectum. In 10 of the 22 cases of cervical fibroids hemorrhage was present, while in 2 instances the tumors were edematous and gangrenous. Operation was rendered difficult in these cases owing to the obliteration of the usual landmarks, the relations of the ureters to the tumor, and the elongation of the uterine arteries. —*International Journal of Surgery.*

Diagnosis of Early Pregnancy with Reference to a Particular Sign.

Louis J. Ladinskl claims that it is always possible to make a positive diagnosis of pregnancy as early as the fifth or sixth week when intrauterine. The diagnosis is made by a single sign. This is the appearance of a spot of a peculiar softness and elasticity just above the junction of the body and cervix in the anterior wall of the uterus, in the fifth or sixth week. When the uterus is retroverted or retroflexed it appears in the posterior wall, and at the sixth or seventh week of pregnancy. In incomplete abortion or subinvolution this area of softening appears, but is much more doughy and less elastic. With a hard fibroid in the upper portion of the uterus there is a similar spot, but the softness is only relative. With a soft myoma in the front of the uterus the feeling is exactly that of pregnancy. The sign must be sought by bimanual palpation. Absence of this sign absolutely excludes uterine pregnancy. The sign aids in making a positive diagnosis of extrauterine pregnancy by excluding uterine pregnancy. It is in all probability due to extreme vascularity of the uterine wall at the point where it is felt.—*Medical Record.*

Cauterization of Inoperable Uterine Carcinoma.

Prochownick (Hamburg Obst. Society, June 19, 1906) reported a case of uterine carcinoma that seemed inoperable four and one-quarter years ago, in which he had made a thorough excochleation. Up to the present time there has been no recur-

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rence. He also presented a patient, forty-eight years of age, on whom six and one-quarter years previously he had done a curettement and cauterization for inoperable cervical cancer, and who now was free from recurrence. Microscopic sections had been made, to verify the diagnosis in this case. The author thinks every such case should be reported, although he believes that wherever possible a radical removal should be attempted.

—*St. Louis Medical Review.*

A Pelvis with a Conjugate Diameter of One Inch.

C. J. Bucura, of Vienna, describes a very unusual case of pregnancy in a woman whose pelvis, as a result of rickets, gave a measurement of but 2 1-2 cms. true conjugate. The extreme deformity is illustrated by an X-ray picture of the pelvis. At the time the patient was carried to the hospital the child had evidently died and the temperature risen to 38.5 degrees centigrade (101.3 F.) pulse 112. A Cæsarean section with removal of the uterus was rendered necessary by the unusual smallness of the pelvis. This was done and the patient made a good recovery. The uterus was not opened at the time of operation. By repeated examinations afterwards a fairly accurate wax model of this deformed pelvis could be worked out. Only four cases of so markedly contracted a pelvis are recorded in all literature.—*St. Louis Medical Review.*

Influence of Hydrogen Peroxide Upon Uterine Hemorrhages.

The writer records favorable results with the injection of hydrogen peroxide into the uterus in two cases of hemorrhage. He claims to have checked by means of but two injections, hemorrhages which could not be controlled in any other way. This therapy was first recommended in 1895 by Petit, who used an applicator, while Spirt employs the Braun syringe. [The abstract does not state the nature of the uterine hemorrhage.—Ed.]—*Spirt, Abstr. in Muenchn. Med. Wochenschr.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages, at $1.00 a year, to be always paid in advance.

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All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

COMMENCEMENT EXERCISES OF THE MEDICAL DEPARTMENT OF VANDERBILT UNIVERSITY.

The annual commencement exercises of the Medical Department of Vanderbilt University were held on the evening of May 1, in the spacious auditorium of the college building on Fifth Avenue, South. The hall was decorated with palms and evergreens, and the proceedings were enlivened with music discoursed by the Italian band.

The hall was comfortably filled with a large and fashionable audience, which witnessed the ceremonies with enthusiastic interest as was manifested by frequent outbursts of applause as occasion demanded. The exercises were opened with an eloquent prayer by Rev. G. B. Winton; the faculty address was delivered in a forcible and impressive manner by Prof. Rich. A. Barr, which address we have the pleasure of reproducing in this number of the *Journal*. The commencement address was made by Dr. J. B. Winton, who took for his subject, "Idealism *vs.* Materialism," presenting advice to the graduate which if followed, will result in good, both to the medical profession and to the individual. The conferring of diplomas was done by Chancellor Kirkland, whose remarks were in the happiest vein of that distinguished orator. The exercises throughout were characterized by smoothness and dignity, and were thoroughly enjoyed by the large and attentive audience.

Diplomas were awarded to the following graduates:

Class Officers.—Henry Thomas Ballantine, President; J. Victor Henderson, Vice-President; David Richard Pickens, Secretary and Treasurer; Walpole Brewer, Historian.

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Graduates.—Alfred Shields Abernathy, Charles Franklin Anderson, Herbert Nowlin Barnett, Hugh Barr, R. E. Bartlett, Jr.; Oval Nelson Bryan, Alexander Joshua Bryant, Niell Dougle Buie, Hervey Carter, Wm. Erwin Chadwick, Webb Earl Cooper, C. D. Conn, Charles Edward Evans, J. Jacques Fabien, Hinton Earl Grizzard, Cleveland Buchanan Hollabaugh, Eugene Jackson, Francis Carleton James, Ive Basc Lackey, Belford Smith Lester, David Campbell Maddox, Richard Leonard Matthews, Martin Alexander Meacham, Harry Donald Miller, Chester Howard McKnight, Will Campbell McRee, Robert Sterling Porter, J. Wilson Reed, Dr. C. A. Rogers, Eliza Green Sandlin, William Gilchrist Saunders, Hunter Ledbetter Scales, Foote Rivers Singleton, William Batt Spain, Jr.; Charles Edwin Spencer, James H. Stephenson, Clyde Oscar Williams, Humphrey Bates Williams and Guy Wright.

Founder's medal awarded to Webb Earl Cooper, Tennessee.

Interneships.—David Richard Pickens, Tennessee, City Hospital; Webb Earl Cooper, Tennessee, St. Thomas Hospital; Hunter Ledbetter Scales, Mississippi, Butterworth Hospital, Grand Rapids, Mich.; James Henry Stephenson, Texas, Providence Hospital, Waco, Tex.; Belford Smith Lester, Kentucky, St. Vincent Hospital, Birmingham, Ala.

Scholarships.—First year class to Lonnie Ray Wood, Alabama; second year class to William Thompson Briggs, Tennessee; third year class to Matthias Brickle Murfree, Tennessee.

The graduates were the recipients of a large number of handsome bouquets and other tokens, which were distributed at the conclusion of the exercises.

The Thirty-second Annual Meeting of the American Academy of Medicine (Specializing in Medical Sociology) will be held at the Hotel Dennis, Atlantic City, on Saturday, June 1, and Monday, June 3, 1907.

PROVISIONAL PROGRAM.

Friday, May 31, 8 p. m.—Annual meeting of the Council.

Saturday, June 1, 10:30 a. m.—Executive Session of the Academy.

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Saturday, June 1, 12 m.—Open session of the Academy.

Report of the Committee on "The Teaching of Hygiene in the Public Schools."

Report of the Committee on "The Comparative Value of the First Degree in Our American Colleges" (final report).

PAPERS.

Dr. Woods Hutchinson, of Arrow Head Springs, California. Value." By Dr. Leartus Connor, Detroit.

"The Superiority of the Playground to the School-room." By Dr. Woods Hutchinson, of Arrow Head Springs, California.

"Insurance for Defectives." By Dr. J. A. Spalding, Portland, Maine.

(There will be a recess for lunch during this session.)

8 p. m.—Open session of the Academy.

Annual address before the Academy—Dr. Casey A. Wood, of Chicago, President of the Academy. "A Medical Career and the Intellectual Life."

Monday, June 3, 1907, 10 a. m.—Executive session of the Academy.

11 a. m.—Open session.

Symposium—The Relation of the Medical Profession to the Housing of the People.

Papers by Drs. Gertrude U. Light, S. A. Knopf, of New York, and others.

Symposium—The Relation of the Profession to Medical Legislation.

Papers by Drs. P. S. Conner, of Cincinnati, Henry W. Cattell, Henry Beates, Jr., of Philadelphia, and others.

There will be a recess for lunch during this session. At the conclusion of the program, there will be an Executive Session, when the report of the Nominating Committee will be received.

7:30 p. m.—Social sessions with the annual banquet, tickets $2 each. Fellows are privileged to bring as many guests (including ladies) as they care to secure tickets. This function is under the supervision of the Committee of Arrangements, Dr. W. Blair Stewart, chairman.

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Some change probably will be made in the order of the papers in the final program.

Every reputable college-bred physician is eligible for membership in the American Academy of Medicine, and it invites all who are interested in the medical aspect of the social problems of the times to unite in its study of these problems. Blank applications and literature may be obtained from the secretary, 52 North Fourth Street, Easton, Pa.

American Medical Association.

The fifty-eighth annual meeting of the American Medical Association will be held in Atlantic City, N. J., June 4-7. In order to secure the best accommodations for the physicians, their families and friends who expect to make the trip to Atlantic City during the meeting, Dr. Geo. H. Price, of this city, has completed arrangements whereby the party will leave Nashville in a special standard Pullman sleeper over the Louisville & Nashville Railroad for Cincinnati, O., and by the Pennsylvania lines from Cincinnati to Atlantic City. The special sleeper will leave this city on June 1.

On the going or return trip, stop-overs will be granted by the Pennsylvania Railroad at Philadelphia, Baltimore and Washington.

A large attendance is anticipated at the meeting. Many physicians throughout the South and West will assemble in Nashville to join the party at this place.

Dr. Charles L. Eves, formerly Demonstrator of Anatomy in the Medical Department of the University of Nashville, and of Vanderbilt University, died in this city in May, 1907.

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Reviews and Book Notices

Physical Diagnosis, with Case Examples of the Inductive Method—By Howard S. Anders, A. M., M. D., Professor of Physical Diagnosis, Medico-Chirurgical College, Philadelphia; Physician to the Philadelphia General Hospital, Tuberculosis Department; Late President of The Pennsylvania Society for the Prevention of Tuberculosis; Member American Medical Association, American Climatological Association, American Association for the Advancement of Science, etc. With eightyeight Illustrations in the Text and thirty-two Plates. D. Appleton and Co., New York and London. 1907.

An exceedingly valuable book to the student. The author insists upon the employment of the inductive method in his investigation of disease as in the method resorted to by Sherlock Holmes in his unearthing of crime as portrayed in the writings of Sir A. Conan Doyle. It is an exceptionally admirable exposition of the difficult subject, and should prove of great use to not only the medical student, but to the practitioner as well.

A Practician's Hand-Book of Materia Medica and Therapeutics, based on established physiologic actions and the indications in small doses. By Thomas S. Blair, M. D. Over 250 pages, bound in limp library cloth. Price, $2, net. Published by The Medical Council, 4105 Walnut Street, Philadelphia, Pa.

Many physicians, being above sectarian prejudice, would honestly use that which is most useful in the materia medica of each different school if it could be clearly pointed out to them and separated from that which is of doubtful value. There is no doubt that each sect has something of value in the agencies it employs in the treatment of disease, or its practice would soon fail. Around this nucleus they have accumulated much material that has little scientific value. It is the duty, as it should be the pleasure, of the physician who wants to do the best he can for his patients to study each school of therapeutics with a view to adopting anything in it that may be better than his own. But there is very much ground to go over, and much of it is stated in peculiar, exclusive terms, not the common language of the profession at large.

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Dr. Blair, a regular physician of very high standing in his profession, has made a close study of the materia medica and therapeutics of each of the sectarian schools, has for many years tested their methods and remedies in his extensive practice, and has carefully noted in each one that which every practicing physician should know and be able to adopt in his practice.

The scheme of this book, as shown from the above statement, is undoubtedly good, as it aims to present the lines of practice of the several schools of medicine as practiced today, and to point out the excellent properties of each without upholding any exclusive system. We feel sure the practitioner of any school will find his ideas broadened and his views more liberal after reading this book.

A Treatise on the Practice of Medicine.—For Practitioners and Students. By Arthur R. Edwards, M. D., Professor of the Principles and Practice of Medicine and Clinical Medicine in the Northwestern University Medical School, Chicago. Octavo, 1328 pages, with 101 engravings and 19 plates. Cloth, $5.50, net; leather, $6.50, net. Lea Brothers & Co., Philadelphia and New York. 1907.

Of the new works that appeal to the profession for patronage, this excellent volume appears to us to meet a want even in this book-making age. Difficult as it is to confine within one volume the mass of knowledge accumulating for years and years, the author has succeeded by thorough system in condensing this information in readily accessible form as represented in this book. A feature of importance is the clearness with which the treatment of diseases is given so that for any given disease the reader can readily formulate a rational and scientific plan of treatment. The following from the preface will serve to give the reader an idea of the author's plan: "The author also conceives that a book on practice should be *well directed,* which implies that it should deal adequately with scientific theories and principles, but that it should recognize that the final object of its existence is the *application of knowledge to the care or alleviation of disease.* Accordingly, an unusual amount of space has been devoted to treatment, to the detailed consideration of drugs and to numerous formulas and prescriptions ready for the student to use

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or improve upon. The physiological action of drugs has been dwelt upon carefully because, in the writer's experience, the symptoms of disease are often confounded with those of the remedies exhibited for its cure." We feel sure that the student and practitioner will find this treatise a treasure in many respects, as it represents in condensed form the completest system dealing with the principles and practices of medicine.

The Essentials of Histology, Descriptive and Practical.—For the use of students. By Edward A. Schafer, F. R. S., Professor of Physiology in University College, London. New (7th) edition, revised and enlarged. Octavo, 507 pages, with 552 illustrations. Cloth, $3.50, net. Lea Brothers & Co., Philadelphia and New York, 1907.

This volume appears in its seventh edition, enlarged and revised through and through in order to bring it fully up with the times. The work is too well and favorably known to the profession to need more than a mere notice. It is full, clear, concise and profusely illustrated. Having been printed on exceptionally fine paper, it has the appearance of a small book, but withal contains 500 pages. No student can afford to be without it.

Manual of Clinical Chemistry.—B. E. A. Austin, A. B., M. D., Professor of Medical Chemistry and Toxicology in the Medical Department of Tuft's College, Boston. D. C. Heath & Co., Publishers, Boston, U. S. A., 1907.

This is essentially a book for the medical student, and is more than any other recent hand-book best adapted to his needs. It presents such practical points of medical chemistry as are needed in understanding diseases, and discards the mass of useless scientific knowledge with which many of the modern text-books upon chemistry are burdened. The author's plan of the make-up is admirable, and its execution is praiseworthy.

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Publisher's Department

Every Physician Knows.

Every physician knows full well the advantages to be derived from the use of antikamnia in very many diseases, but a number of them are still lacking a knowledge of the fact that antikamnia in combination with various remedies, has a peculiarly happy effect; particularly is this the case when combined with salol. Salol is a most valuable remedy in many affections; and its usefulness seems to be enhanced by combining it with antikamnia. The rheumatoid conditions so often seen in various manifestations are wonderfully relieved by the use of this combination. After fevers, inflammations, etc., there frequently remain various painful and annoying conditions which may continue, namely: the severe headaches which occur after meningitis, a "stitch in the side" following pleurisy, the precordial pain of pericarditis and the painful stiffness of the joints which remains after a rheumatic attack—all these conditions are relieved by this combination called "Antikamnia & Salol Tablets," containing 2 1-2 grains, each of antikamnia and of salol and the dose of which is one or two every two or three hours. They are also recommended highly in the treatment of cases of both acute and chonic cystitis. The pain and burning is relieved to a marked degree. Salol neutralizes the uric acid and clears up the urine. This remedy is a reliable one in the treatment of diarrhoea, entero colitis, dysentery, etc. In dysentery, where there are bloody, slimy discharges, with tormina and tenesmus, a good dose of sulphate of magnesia, followed by two antikamnia and salol tablets every three hours will give results that are gratifying.

An Annual Visitor.

We have just passed through our annual epidemic of la grippe, which as usual, claimed its victims among all classes and conditions, mainly, however, among the classes where the resisting

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power was below par, or among sufferers from some chronic ailment. While the sequelae and complications of this disease may assume almost any phase of acute inflammatory character, its primary effect is upon the nervous system. Therefore, we have no hesitancy in saying, no matter what the local inflammation may require as a medicine, by all means give antikamnia tablets as a nerve sedative and to relieve the muscular pains always present. We have seen a violent cough of bronchitis treated upon the general plan, with the cough as distressing at the end of twenty-four hours as at the beginning, promptly yield to six antikamnia tablets during an interval of six hours. La Grippe usually requires a double treatment, one directed to the influenza, and the other devoted to the complications, be they of the respiratory organs or digestive tract. In all cases antikamnia tablets will be found to perform a prominent and successful part and purpose.—*Medical Reprints.*

Powder Burn of Face.

BY E. KUDER, M. D., COFFEYVILLE, KAN.

About a year ago I was called in a hurry to relieve the awful suffering of Carl Rucker, of this city, ten years old, who when playing with other boys exploded about two ounces of coarse black shooting powder in a little earth mound, and not being quick enough to turn away, got the most of the discharge into his face; even the conjunctivæ of both eyes were blackened, and from the burn and subsequent inflammation, shut tight; one of the ears also got burned very badly.

To extract the powder from the skin, I have in years gone by applied a thick layer of castile soap made into a sort of dough, and as I had to deal here with the inflammation and pain beside, I scraped a cake of shaving soap, mixed it thoroughly with Antiphlogistine, and applied it about one-half inch thick all over the face and ear, leaving a hole for the eyes, nostrils and mouth. About one-half hour later, the little patient, a very sensible child, rested very comfortable, free from pain and slept a few hours soundly. About twenty-four hours later I removed the whole

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mask from the boy's face and to my great delight and surprise the application had drawn out every kernel of the powder. The inflammation had been greatly reduced, pain was all gone and the face appeared almost natural again, with the exception of the sclera of both eyes, which I treated with a solution of cocaine adrenalin.

Another remarkable circumstance is the fact that the boy, at the same time, got entirely rid of his freckles, not a trace of the latter could be detected. For about a week the face got anointed with cold cream twice daily, and being well, was discharged as cured.

Gastric Immotility.

A large proportion of all cases of indigestion are the result of weakness of the muscular walls of the stomach. Insufficient motility is followed by dilatation and this by excessive fermentation of the ingested food.

To overcome the presenting condition it is urgently necessary to increase the muscular activity of the stomach walls, and it is well known that this is one of the most valuable properties of Gray's Glycerine Tonic Comp.

Increased activity of the muscles of the stomach means improved circulation, and this in turn exerts a beneficial influence on the secretory functions. Thus, excessive fermentation and other distressing symptoms are logically overcome with actual instead of temporary improvement in the whole physical condition.

Sanmetto in Prostatitis, Chronic Cystitis and Enuresis.

I have had a very large experience with Sanmetto in prostatitis so common in old men, also in chronic cystitis in both sexes, and find it prompt, efficient and reliable in these and in all other cases of irritability of the genito-urinary organs. Have also used it with great satisfaction in enuresis; in fact I think it will cure any case where no mechanical cause exists.

Aurora, Ind. Edw. J. Libbert, M. D.

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A recent and very plausible theory ascribes rheumatism—"To toxines formed in the alimentary canal as the result of disordered digestive functions, producing disturbances in metabolism and alteration in the tissues. The body suffering these effects of authintoxication has its vital resistance lowered and is therefore subject to microbic invasion."

Tongaline from the character of its composition has an antitoxic effect on these microbes and by its stimulating action on the liver, the bowels, the kidneys and the pores, it eliminates promptly and thoroughly the poisonous germs which are the cause of rheumatism, neuralgia, grippe, gout, nervous headache, sciatica, lumbago, tonsilitis and heavy colds.

Pepsin is undoubtedly one of the most valuable digestive agents of our Meteria Medica, *provided a good article is used. Robinson's Lime Juice and Pepsin* (see page — this number), we can recommend as possessing merit of high order.

The fact that the manufacturers of this palatable preparation use the purest and best pepsin, and that every lot made by them is carefully *tested,* before offering for sale, is a guarantee to the physician that he will certainly obtain the good results he expects from pepsin.

Stone Ridge, N. Y., November 27, 1906.

The Anasarcin Chemical Co.,

Winchester, Tenn.

The sample "Anasarcin" you so kindly sent me I used upon the following case: P. J., male, merchant, age 65; heart dropsy; limbs swollen to knees very bodly; compelled to bandage them; very short of breath; could not lie down; what little sleep he obtained was had sitting in chair. His family gave up all hopes of his recovery. On the morning of the eighth of November commenced "Anasarcin," three tablets a day and every other day a tablespoonful sulphate magnesia. On the eighteenth November discontinued my visits as the swelling had entirely disappeared; he could sleep in bed with comfort; appetite good and patient

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in excellent spirits. I advised him to continue one tablet of the medicine before each meal three times a day for a few days. To-day he is attending to his business as usual and continues in fair health. Prior to using Anasarcin I had about exhausted the list recommended in such cases and given up hope of the patient's recovery.

Very truly yours,

HERMAN CRAFT, M. D.,

P. S.—You may make use of this letter if you desire. H. C.

Dallas, Texas, October 31, 1906.

The Anasarcin Chemical Co.,

Winchester, Tenn.

I herein acknowledge receipt of tablets sent me some time ago, and I am glad to say that I never used a medicine in dropsy resulting from heart trouble with more satisfactory results. I shall prescribe them hereafter, in all similar affections.

Yours truly,

J. W. ANDERSON., M. D.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. JUNE, 1907. No. 6

Original Communications

*THE CARE OF THE PERINEUM.

BY J. W. BRANDAU, M. D., CLARKSVILLE, TENN.

While I do not believe in "meddlesome midwifery," there are some things which can be done to aid nature to bring about a successful accouchement. One of the most important of these aids is the care and preparation of the perineum for the great strain that it is subjected to in the passage of the head.

The bladder and lower bowel should be empty. The membranes should not be ruptured too early, as the pyramidal bag of waters aids in dilating the perineum. Further dilation of the perineum is done by means of the following method taught by the lamented Professor Menees: Having thoroughly cleansed the hands—as for a surgical operation—the operator introduces first one, then two fingers, the tips of which reaching to the point of the coccyx, the patient on her back, and during the pains a firm, steady pressure downward and backward is made upon the perineum until that structure is felt to be thoroughly relaxed. The time which the dilating will occupy will depend upon the rigidity of the perineum, being naturally longer in the primipara. The pressure of the right may be reinforced by the fingers of the

*Read before Montgomery County Medical Society, June 1, 1907.

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left, or, vice versa, by placing them across near the knuckles, if the perineum be very rigid, requiring heavy and prolonged pressure. The dilating should begin about the time the head is nearing the lower strait of the pelvis, and continued until there is sufficient dilation, or the head is almost ready to pass over the perineum, when the fingers are removed; and the inner border of the palm is pressed against the perineum; the other part of the palm resting against the head, more or less pressure being applied, according as the uterine contractions are strong or weak; thus controlling the passage of the head, allowing it to pass over the perineum in the interval between pains, if possible. The support to the perineum is continued until the shoulders and hips are delivered.

The fact that dilating the perineum increases uterine contraction, has been mentioned by some writer as an objection, as it might cause too rapid a delivery of the head. I think there is usually a slight increase in contractions, but only while the dilating pressure is being continued; and this is left off before the head passes the vulvar orifice. Some patients will complain of increased pain, but when it is explained that the object is to lessen the danger of laceration, and shorten the time of labor, there is never further objection. I have never found it necessary to resort to incisions. In about 700 deliveries I have not had a complete laceration, and I cannot recall more than half a dozen cases having sufficient tears to require one or two sutures.

One of the sources of infection of the lying-in patient is laceration of the perineum. In the number mentioned there were three of infection, one, cause unknown; one, due to injuries to the vagina in a high forceps delivery; and one, a case of post-partum hemorrhage in which the hand was passed into the uterus without time for proper disinfection.

In forceps deliveries, after dilating the perineum as described, the instruments are applied, the head brought down well against the floor of the pelvis, the blades removed, and the delivery completed in the usual way.

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Beyond the Surface.

BY B. F. FYKE, M. D., SPRINGFIELD, TENN.

Were I called upon to designate the man that is the greatest benefactor and philanthropist, I would name the physician. Of all callings and professions among men, what is grander and nobler than the practice of medicine? Who has a higher mission than the physician? He is called to see the rich and the poor; the high and low in the walks of life. He wields a peculiar influence in the moral, legal and social functions of a community. What is his calling? To combat disease and ward off death. What is his vow? To offer relief to all who suffer the pangs of pain, to restore sight to the blind, and hearing to the deaf. Who has furnished more illustrious examples of self-sacrifice and heroism than the physician? Who carries more secrets, in his bosom, of deeds well done, of which the world is ignorant, than the physician? Compare the Christian missionary among the heathen nations and the warrior on the bloody battle-field to him in the sick-room at midnight, bending over a sick child, the idol of its parents.

Who has done more to make the world a better place than the physician? What science has a brighter page in history and made greater advancement than the science of medicine and the practice of surgery? See what it has done all over the world—robbed smallpox of its terror, cured cholera, yellow fever and diptheria, and is in close pursuit of tuberculosis. The "boy surgeon" of today successfully performs operations that the aged of thirty years ago would not undertake. Then, who is a physician, and who is mindful of him? His is a great mission.

NOW, BEYOND THE SURFACE.

The question I wish to submit for your consideration and discussion, and which I think overshadows all others in importance, is the imperative need for higher literary attainments and more thorough training in those who wish to begin the study of medicine. What has been done of late in this direction is only the beginning of what should be done. We should not cease in our efforts in this direction until every young man proposing to begin

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the study of medicine has at least a high-school or a preparatory school education.

It is impossible to over-estimate the importance and value of a high degree of mental training and discipline in the physician. He thinks deeper and reasons higher, and has a loftier conception of ideas; he knows what to think and how to think; his memory is well trained; he is quick in reason and judgment, and acute in observation.

The church is calling for a higher educated ministry, and the public schools are demanding thorough training and higher education in its teachers, and the grades to be made are raised every year. The lack of mental training and discipline explains in a large measure why so many graduates in medicine fail before the State Boards of Medical Examiners every year.

Think of a young man beginning the study of medicine that is so deficient in education that he will use taken for took; I seen, for I saw; dostes for doses, and spell oakum. ochre, and ipecac, eppercack; in the Roman notation, writing two v's for 10, four x's for 40, and beginning the first line of a letter with a capital letter. Such men, if graduated, then licensed to practice medicine, are prone to become the dupes of the proprietary representative and the prey of the patent medicine vender; and they make the quacks, charlatans and irregular doctors of our country.

When such men are found is the reflection on the medical college that graduated them, the board of examiners that licensed them, or on the doctor? Now, inasmuch as every State has a statute regulating the practice of medicine and surgery, and a board of medical examiners, and all graduates of medicine must pass before this board for license to practice medicine, let the attainments and qualifications for admission to a medical college be such, and the grades to be made for graduation be so high that a diploma from the college will be evidence enough for a license to practice medicine.

Let the medical profession lend a helping hand in the matter by discouraging all who are not qualified to begin the study of medicine and advise them to obtain a literary education, and see

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that broad-minded and liberal and non-political doctors are appointed on the board of examiners.

Have this motto: *Beyond the surface.*

Obstetrics and Gynecology.

BY E. S. MC KEE, M. D., CINCINNATI, OHIO.

Pruritus Vulvae.

This is so terrible and intractable an affection that any mode of treatment should be welcomed which affords relief. In the *Deutcher Medizinischer Wochenschrift* for October 4, 1906, Rotschub reports a case cured by ultra-violet light. After four applications the patient was relieved and was enabled to sleep. Twelve applications effected a complete cure. There are numerous reports in current literature of the relief of itching by treatment with *x*-rays and high frequency. Permanent relief has occurred in several instances from the use of radium irradiation.

The Reamy Birthday Dinner.

This is the title of a beautifully bound book just received. It contains the speeches and engravings of the speakers at the Reamy banquet, given at the seventieth anniversary of Dr. T. A. Reamy's birth, at Cincinnati, Nestor in obstetrics at the St. Nicholas, on April 28, 1899. First is a fine engraving of Dr. Reamy at fifty-seven, after he had parted with his flowing chestnut beard. Then came reproductions of the invitations and the menu card and a list of those present. A fine engraving of Dr. P. S. Connor followed, and his introductory remarks as toastmaster. Then came the engraving and remarks of Dr. N. P. Dandridge; then an engraving of Dr. Reamy at seventy, and his response. Next comes the engraving of Dr. J. T. Whittaker, and that pearl of this collection of pearls, his remarks on the subject of "The Old Guard." Dr. Whittaker was then stricken with that malady, which in a little more than a year must and did carry him off. Many of his remarks seemed doubly appropriate. "The silent organ loudest chants the Master's requiem." Drs. McMurtry and Mathews, of Louisville; W. H. Taylor, Judge David

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Davis, and Rev. Wm. H. Moore responded, while the prayer of Prof. P. V. N. Meyers, with which he closed his address, "God bless our dear and honored friend! God keep him, and call him from us late, very late," seems answered. Dr. Reamy, though in very feeble health, and obliged to spend the winter in the sunny Southland, has quite recently returned to us.

Rotunda Hospital Report.

The report of this Dublin institution is replete with information. Placenta previa was observed but three times during the year, and in all the placenta was felt by vaginal examination. Hemorrhage, in every instance, was considerable. In two bi-polar version was undertaken; the cases were afterwards left to nature. Both children were born dead. In the third the woman entered the hospital on account of considerable flooding. She remained under observation in the hospital for a few days, when labor started and she delivered herself of a living child without further bleeding.

Accidental Hemorrhage.

There were eight cases with this complication. In two the loss of blood was not great and no special treatment was called for. In another, good labor pains were in progress and the application of a bandage controlled the bleeding. In four the vagina was plugged after the Rotunda method with happy results.

Rupture of the Uterus.

One case occurred in the Exter Maternity, bipara, age 26; admitted to the hospital undelivered. Labor had started at 8 a. m., membranes ruptured an hour later, and pains continued strong until 10:30 a. m., when they ceased altogether. Rupture of the uterus was diagnosed and she was sent to the hospital. The forceps were at once applied with the head fixed in the brim, occipito-posterior position, with os almost fully dilated, the body of the child lying free in the abdominal cavity. Delivery was easily accomplished and a rent was found involving the cervix and the posterior wall of the vagina. The placenta, which lay free in the abdomen, was removed by the hand. The patient's condition did

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not seem to warrant operation and the rent was plugged with iodoform gauze. Death followed in four hours.

Podalic Version

was undertaken ten times, twice for placenta previa, twice for prolapse of the cord, and three times for flattened pelvis; in another hydramnios complicated a cross birth.

Caesarean Section

occurred four times, in one case the second operation on the same patient.

Post Partum Hemorrhage.

Nineteen cases are recorded. One case was purely atonic and required plugging with iodoform gauze. In eight the hemorrhage was associated with retained placenta, all of which required manual removal. Hot uterine douches were successfully employed in all other cases.

Spontaneous Inversion of the Uterus.

This very rare accident arose during the labor of a primipara, who was delivered of a full-term child by natural efforts. The uterus contracted well at the termination of delivery. The separation of the placenta was left entirely to nature. In twenty minutes the patient cried out as though in labor and declared that the pains were as bad as when the child was born. The placenta and fundus protruded through the vulva and a hollow was felt over the pubes. A gloved hand was at once passed through the vagina and an adherent placenta was felt firmly attached to the fundus of the uterus and removed. While this was being done another pain was started and the organ was turned completely inside out, its fundal extremity protruding through the vulva. No difficulty was experienced in its reduction. The puerperium was uneventful and apyretic.

Rectal Obstruction Caused by Calcified Uterine Myoma.

An unmarried woman, aged 70, had suffered for some months from an obstruction which had in the last few weeks become

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worse. Rectal examination showed a hard, irregular growth, situated in the pouch of Douglas, and attached to the utero-vaginal walls. A diagnosis of rectal cancer was made. Laparotomy revealed a stone-hard tumor the size of the fist. This was easily separated from the atrophic uterus, with which it seemed to have but little connection. Its irregular projections rendered its separation from the rectal and posterior vaginal walls difficult. Microscopically it proved to be a markedly calcareous myoma. Calcification occurs generally in subserous fibro-myomata and rarely in others. When they become detached, as is frequently the case, they form the so-called "uterus steine."—*Deutsche Zeit Schrift fuer Chirurgie.*

Migration of a Gauze Sponge Left after Laparotomy into the Bladder.

Dr. W. Stroeckel (*Zent. f. Gynak.*) says there are 200 cases on record in which, after laparotomy, sponges, towels, scissors, clamps, forceps, etc., were unintentionally left in the peritoneal cavity. Although such foreign bodies may become incapsulated (when aseptic) or escape outward or into the intestine and bladder, the latter is the most rare of all. He reports the case of a girl of 24, who had been laparotomized in July, 1906, for diseased ovaries. A sinus was left which communicated with the bladder. Cystoscopic examination revealed a foreign mass projecting into the bladder interior. With forceps the body was extracted and proved to be a gauze sponge. Inquiry discovered the circumstances that at the time of the first operation the bladder was injured and repaired, with later urinary fistula, which healed spontaneously. The writer thinks that the possibility of overlooking sponges, etc., may happen to the best operators.

Spontaneous Expulsion of the Carcinomatous Uterus after Cauterization with Chlorid of Zinc.

Dr. A. Blau (*Zent. f. Gynak.*), in reporting this extraordinary case, warns against the dangerously penetrating, cauterizing power of chloride of zinc.

A woman of sixty-four was suffering from pyometra associated

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with carcinoma of the cervix and uterine interior. After dilating the cervix and permitting the purulent retained discharges to escape, a rubber drainage tube was left inside for several days. A radical operation was projected, but in view of the foul, persisting discharge a strip of gauze saturated with 30 per cent. chloride of zinc was introduced into the uterine interior and removed after fourteen deays. After this the uterine cavity was washed out every second day with hydrogen peroxide. On the eighth day a sac was found in the vagina having the shape of the uterus. Under the microscope it proved to be the interior of the uterus, including the musculosa. In other words, the entire carcinomatous uterus and cervix (possible down to the peritoneal covering) became spontaneously detached and was expelled. The patient left the hospital well, with parametric exudates, which were either inflammatory or malignant.

The Surgical Cure of Prolapsus of the Vagina and Uterus.

Dr. A. D. Duhrssen (*Gynak. Rundschau*) says the cure of prolapsus by operative measures implies: (1)Removal of excessive vaginal tissue; (2) construction of a firm pelvic floor; (3) restoration of the normal position and size of the uterus; (4) proper treatment of the cystocele.

Colporraphy fulfills the first indication. Colpoperineorraphy accomplishes the second end. The author modifies the Hegar incision by outlining a five-cornered area of denudation and making sure that the perineal muscles are properly restored by the sutures.

The size of the uterus is diminished when necessary by an amputation of the portio or of the entire cervix. The position of the uterus is restored by a vagino-fixation operation, as advocated by the author since 1893.

The treatment of the cystocele is the most important feature of the operation. On the anterior vaginal wall an inverted T incision permits of a thorough dissection of bladder and ureters from their connection with the vaginal and uterine walls. The peritoneal cavity is opened and the adnexa explored or treated surgically. Adhesions of the uterus are broken up. The bladder

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having been crowded high up above the uterine fundus, sutures are passed so as to include both edges of vaginal mucosa and peritoneum in the line of incision and the exposed anterior uterine wall. The result of this is that the bladder is permanently dislocated upward and its descent prevented by the uterus attached to the vaginal incision. In cases of young women in whom the probability of future pregnancy exists, the peritoneal wound is closed independently and only one silk suture attaches the uterus to the vaginal wound.

As the result of ten years' experience with this method of procedure, the author, while admitting that he frequently is obliged to remove the uterus in advanced cases, expresses great satisfaction with it.

The Treatment of Overian Prolapse by Shortening the Ovarian Ligament.

1. Primary ovarian prolapse uncomplicated by retroversion or disease of the appendages results from adnormal elongation of the ovarian and ovarico-pelvic ligaments. A stitch of a silk thread catches the uterine wall posteriorly and is passed along the ovarian ligament in a "gathering stitch" up to the ovary, when both ends are tied and the ovary is raised and attached to the fundus of the uterus at a greater or lesser distance from the cornea. The other ovary is treated in the same manner.

2. Ovarian prolapse caused by, or complicated with, chronic disease of the ovary or tube, to which fixed retroversion may or may not be added: "In these cases the operation of salpingo-oophorectomy is the one which we should most seek to avoid." The author strongly favors conservative operations on the ovaries, and an attempt should be made to prevent the return of these organs to the diseased peritoneal bed from which they have been separated. In these cases the ovaries or portions of ovaries are brought up and attached under the uterine cornua by the operation described. Ventro-fixation is now added. The author thinks that he thus secures the following results: The removal of the cause of the disorder, the inflamed tubes; the conservation of the ovaries in a position removed from the diseased area, in

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which, therefore, they stand the best chance of ultimate recovery; the avoidance of the possibility of post-operative retroversion.

The Cause of Common Baldness.

Parker (*Med. Record*) discusses the theory that makes common baldness depend for its existence upon a double cause, one being the remote or fundamental cause represented by the absence of upper chest breathing, a condition that allows a poisonous substance to develop in the lungs. The other, the direct, or exciting cause, represented by the effect produced by this poisonous substance circulating in the blood. The writer states that common baldness accounts for more than ninety per cent. of all cases. He offers much interesting evidence in support of his theory.

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Correspondence

McMinnville, Tenn., May 11, 1907.

Editor Nashville Medical Journal: Following is a partial history of a case which is unique in my experience:

I., native of Warren County, Tenn., male, white, age about forty years, a farmer, married, came to my office about two months, age, and asked to have his urine examined. His reasons for this were, that he had lost a boy about six years old, a few months ago, with nephritis; his father died eight or ten years ago as a result of a foreign growth in his bladder, evidently malignant, and this patient had recently been having a sharp, shooting, intermittent pain just above the pubis in the region of the space of Retzius.

He had not noticed anything abnormal about the urine, but seemed uneasy on account of deaths in his family from diseases of the urinary organs. I tested a sample of his urine, and found it normal, save as regards reaction and specific gravity. The reaction was decidedly alkaline, and the sp. gr. 1006. I suspected albumin, but after careful tests by different methods, could find none. I then made a microscopal examination, but could find no evidence of inflammation of kidneys or of any other portion of urinary apparatus. I questioned him about symptoms of diabetes insipidus, nervous affections, etc., which might account for the low sp. gr.; questioned as to food and drink, and investigated as to condition of bladder, retention of urine, etc., which might account for reaction. Could find no cause for either. He seemed perfectly well in every way except this condition of urine. He does not know how long this condition has existed. I had him to save and measure the quantity of urine passed during twenty-four hours. He reported three pints. I have tested the urine again and again, during the past two months, and it has persistently shown a low sp. gr., and alkaline reaction. I gave him benzoic acid to render urine acid, but as soon as this was stopped, it became alkaline again. The sp. gr. varies from 1002 to 1012

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as a rule. The quantity, consistence, transparency, odor, color, etc., remain normal. I have given various agents supposed to cause elimination of solid waste matter by the kidneys, but cannot get urine up to a normal sp. gr. Patient continues in good general health, but still complains of occasional shooting pains in pubic region, and yesterday, for the first time, he claimed to feel numbness in his arms and legs. He did not know whether this was imaginary or whether he really felt it.

His appetite, digestion, circulation, respiration, temperature, nutrition, weight and strength are unimpaired, and he continues to work on his farm as usual.

What is the cause of the urinary conditions, and what will be the outcome of the case?

ALBERT SEITZ, M. D.

ELECTION OF OFFICERS OF A. M. A.

At the recent meeting of the House of Delegates of the American Medical Association at Atlantic City, the following officers were elected, and standing committees appointed.

The House of Delegates reconvened at 2 p. m. and was called to order by the President.

The Secretary called the roll and 81 members responded.

After the roll-call, the election of officers was in order.

The President appointed as tellers Drs. Wisner R. Townsend, New York; S. Bailey, Iowa; George W. Webster and Robert T. Gillmore, Illinois.

The following officers were nominated, balloted for and duly elected:

President—Dr. Herbert L. Burrell, Boston.

First Vice-President—Dr. Edwin Walker, Evansville, Ind.

Second Vice-President—Dr. Hiram R. Burton, Lewes, Del.

Third Vice-President—Dr. George W. Crile, Cleveland, Ohio.

Fourth Vice-President—Dr. W. Blair Stewart, Atlantic City, N. J.

General Secretary—Dr. George H. Simmons, Chicago.

Treasurer—Dr. Frank Billings, Chicago.

Trustees—Dr. T. J. Happel, Trenton, Tenn., re-elected; (1907-

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1910); Dr. W. W. Grant, Denver, re-elected (1907-1910); Dr. Philip Marvel, Atlantic City, N. J., re-elected (1907-1910).

The other members of the Board are: Dr. E. E. Montgomery, Philadelphia, Pa., 1908; Dr. A. L. Wright, Carroll, Ia., 1908; Dr. H. L. E. Johnson, Washington, D. C., 1908; Dr. M. L. Harris, Chicago, Ill., 1909; Dr. Wm. H. Welch, Baltimore, Md., 1909; Dr. Miles F. Porter, Ft. Wayne, Ind., 1909.

The following nominations were made by the President and confirmed by the House of Delegates:

Committee on Medical Legislation—In place of Dr. W. L. Rodman, Dr. C. S. Bacon, Illinois.

The other members of the committee are: C. A. L. Reed, Cincinnati, Ohio, chairman, 1909; Wm. H. Welch, Baltimore, Md., 1908.

Council on Medical Education—In place of Dr. Charles H. Frazier, Dr. James W. Holland, Pennsylvania.

The other members of the Council are: Arthur Dean Bevan, Chicago, Ill., chairman, 1909; W. T. Councilman, Boston, Mass., 1910; J. A. Witherspoon, Nashville, Tenn., 1911; Victor C. Vaughan, Ann Arbor, Mich., 1908.

Committee on Transportation and Place of Session—Dr. M. L. Harris, Chicago; Dr. E. Eliot Harris, New York; Dr. W. A. Jayne, Denver; Dr. W. T. Sarles, Sparta, Wis.; Dr. John C. Munro, Boston, is chairman of this committee.

Committee on Organization—Dr. J. N. McCormack, Bowling Green, Ky.; Dr. George H. Simmons, Chicago; Dr. Philip Mills Jones, San Francisco.

Board of Public Instruction on Medical Subjects—Dr. J. G. Clark, Philadelphia, 1907-1911; Dr. F. F. Simpson, Pittsburg, 1907-1911; Dr. Frank Billings, Chicago, 1907-1910; Dr. George H. Monks, Boston, 1907-1910; Dr. L. S. McMurtry, Louisville, Ky., 1907-1909; Dr. Howard Kelly, Baltimore, 1907-1909; L. Emmett Holt, New York, 1907-1908.

Judicial Council—C. E. Cantrell, Texas; R. C. Cabot, Massachusetts; G. W. Guthrie, Pennsylvania; Thomas McDavitt, Minnesota.

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Selected Articles

ADDRESS.

The American Medical Association, It's Aims and Interests.

PRESIDENT'S ADDRESS AT THE FIFTY-EIGHTH ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION JUNE 4-7, 1907.

By Joseph D. Bryant, M. D., of New York City.

The fifty-eighth consecutive session of the American Medical Association is now at hand. Those members whom you kindly honored one year ago with your confidence in official station are now before you in token of their loyalty to your undertakings and of their obedience to your behests. These annual conferences are of prodigious moment to the entire medical profession and to the country at large; they serve to broaden the scope of general understanding; they extend the sphere and increase the vigor of professional fellowship and of healthy civic brotherhood, and they correspondingly elevate the station of our calling in the appreciation of thoughtful right-minded people everywhere in the land. Who of us was not made a better physician because of the visit to Boston a year ago? Who of us, then inspired by patriotic emotions, aroused by the memorable examples so abundantly at hand, did not again renew unalterable allegiance to the perpetuity of his country? In whom of us was not incited a higher fraternal sentiment by the warm grasps of fellowship which, while inviting delay a bit, everywhere urged us to a completed hospitality?

Again, for the third time, in the dawn of the twentieth century, we find ourselves in the warm embraces of the hospitable people of Atlantic City. Its wealth of sunshine and cheer, its pure and invigorating eastern breezes, and the joyous acclaim of its citizens assure us that we are in "honest waters which ne'er left man i' the mire," and, therefore, we feel entirely secure and corre-

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spondingly happy. We who before never yielded to subtle solicitation or to pressing demand now acknowledge that we have the Atlantic City "habit," and we refuse all treatment except that founded on the therapeutic virtue of the hair of the canine that inflicted the delightful traumatism! In the presence of such a felicitous environment as this, who is there among us who would be so thoughtless, or who could be so unfeeling as to countenance a trifling with the sense of justice, by individual favor, or of commendable desire by vain objection?

In looking about for a topic on which to base my allotted remarks on this occasion, I am, perhaps, unduly impressed with the idea that impersonal open-hearted introspection might not be amiss at this period of the association.

In this bearing I refer more especially, 1, to the organizing of the medical profession of the country and its potential perplexities; 2, to the elevating of the standard of medical education and its possible afflictions, and, 3, to the urgent demand for trustworthy medicinal means and of sincerer efforts on the part of every physician in securing a betterment of therapeutic methods.

Equity, consequent power and the durability of human designs are the legitimate assets of wisely conceived organization. Power and durability, not thus sustained, are of uncertain tenure, and organization resting thereon can be likened to a house of blocks tethered with ropes of sand. And it should be recognized at all times that the virile activities of the principles of human justice are wonderfully potent in all organized bodies of mankind.

THE OBJECT OF THE ASSOCIATION.

It is of great moment that this association has (as set forth in its constitution) but one significant object in view, viz., "The Promotion of the Science and Art of Medicine." And it is purposed in attaining this end "to unite into one compact organization the medical profession of the United States," in order to foster "the growth and diffusion of medical knowledge;" to promote "friendly intercourse among American physicians;" to safeguard "the material interests of the medical profession;" to elevate "the standard of medical education;" to secure "the enactment and

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enforcement of just medical laws;" to enlighten and direct "public opinion" regarding the "broad problems of hygiene," and to present "to the world accomplishments of scientific medicine."

It follows, therefore, that the promotion of the science and art of medicine as provided by the constitution of the association is, in effect, the promotion of the methods and the development of the means and the opportunities for relieving human suffering and thereby the adding of years and comfort to human existence. And true it is that to no class of persons is fraternal spirit and vigilant co-operation so essential as to those who are engaged in combating the insidious and tireless encroachment of the agents of human affliction and in relieving the abundant miseries which they beget. A transcendant service like this should be sheltered by the zeal of healthful personal and professional devotion, and in no way depleted by the wiles of business ambitions. Those who regard the practice of medicine as a business enterprise should class themselves as brokers in a market of human affliction. To those who would infect the sound spirit of professional devotion and fellowship with the virus of sordid gain little heed need be given at the counsels of thoughtful men in the ranks of a beneficent profession.

The uniting of the medical profession of the United States into "one compact organization," making to the wise purposes already stated, is progressing in a decided manner, guided by the earnest activity and abundant experience of Dr. J. N. McCormack, of Kentucky. Already the constituent members of the organization number nearly 65,000, of which the fully constituted members are about 27,000, showing a substantial increase of the former class during the present year of about 10 per cent and of the latter about 12.5 per cent. And when it is recalled that the regular medical profession of the United States numbers about 112,000 it is not difficult to understand that in the near future the medical profession of these States might easily be united into one compact organization. But how compact it may be and how enduring it may become will depend on the degree of wisdom exercised by its builders and on the measure of justice dispensed by those in control of its affairs.

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"Justice without wisdom is impossible," said Froude. "Wisdom is only truth," said Goethe. Therefore, justice and truth are inseparable, say we all. The search for truth and understanding is the inherent right of all men, and they who inhibit the effort are for some reason (or pretext) opposed to justice and to knowledge. Obviously the consensus of men of widely separated habitation, of differently constituted environment and opinion, is a wiser and a safer guide in the conduct of important and comprehensive human affairs than is the consensus of men of contiguous localities. The judgment of the former class represents the concentrated wisdom of the whole, of the latter only that of a part of the country. The principle of utterance or of action relating to matters of common interest and general effect in organized bodies should, in all cases, be known and approved and be co-ordinated through the deliberate wisdom of broad constituted authority, rather than by the anxious thought or the hasty vocabulary of a few persons, no matter how experienced they may be or how wise they may be regarded as being. History not infrequently has demonstrated by untoward results the need of this rule of action in governmental and in other human affairs.

The lamented Lincoln emphasized the importance of this principle in no uncertain manner by the famous utterance, "The government of the people, by the people, for the people, shall not perish from the earth."

And in this relation it is well for us to keep in mind that a failure on the part of the responsible many, to plan and co-ordinate wisely the official acts of the few, often renders effeminate and inoperative the subsequent inhibitory efforts of those in established control.

Among the inspiring benefits provided by the constitution of this association is embraced the fostering of the growth and the diffusing of medical knowledge and its beneficence, throughout the various channels of human intercourse. The promoting of the growth and the diffusing of medical knowledge should appear with equal vigor to the people who experience relief and to those who contribute the products of medical enlightenment.

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Every physician can contribute a definite share to the healthy growth and wise diffusion of medical knowledge and to its bounties. Those who strive in the workshops of medicine, the laboratories and the hospitals, more especially the former, have already bestowed a bountiful portion toward the attainment of this end. Scientific laboratory deductions, however, could not be regarded as final; they yet required the leavening proof from out the complex laboratory of the human body, as demonstrated by practical applications in the treatment of disease, to establish their worth. To the general and to the hospital practitioners of medicine belonged the duty of dispensing the fruits of laboratory research, and thus far so well has concurrent effort accomplished its purpose, that life's expectancy during the first forty years of existence has been advanced quite 30 per cent. But following this period only a little advance in this regard has yet been made, and principally because of the differences in the nature of the diseases which afflict those of the earlier and of the later periods of life.

The present and prospective civil worth of the toll levied by disease on the wisdom and experience of mankind during the later period of life cannot well be estimated. But the physical sufferings of this period are largely the characteristic outcome of its peculiar diseases, many of which might be prevented and perhaps cured by means of progressive investigation and therapy related to a full term of years, and thus life's span becomes yet longer extended.

As yet observed, every physician, if he will, can contribute a definite share to this pre-eminent undertaking. The opportunities of the country practitioner in this regard are of special significance, because of the knowledge gained through the differing effects of environment on the disease of the country and urban patients. Painstaking co-operative effort directed to the solution of the problems of disease can be made wherever two or more physicians are in mutual contact with each other and shall undertake the task.

MEDICAL EDUCATION.

It cannot be gainsaid that the comparatively few of the people constituting the medical profession of this country are tireless in

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their efforts to advance the scientific and practical status of medical knowledge. But what can be said regarding the great multitude of others of the people, referable to mutual response commensurate with the earthly blessings which they receive? As an earnest of the sentiments of those persons who give bountifully to beneficent ends, I quote from a comprehensive address delivered by President Keen at the annual session of this association, held here in June, 1900, and based on the United Education Report of 1898. President Keen presented to the audience the following startling facts regarding the comparative endowments bestowed on theological and medical schools for teaching (not foundation) purposes in this country. It was shown that each of the 8,000 theological students had the income of $2,250 provided for his instruction, and that each of the 2,400 medical students had the income of $83 provided for the same purpose. Also that of the 178 endowed chairs in teaching, only five related to medicine. Then we were solaced by the thought, "A hard beginning maketh a good ending."

In this address President Keen gave as his opinion that the difference in the amounts of these endowments was chiefly in consequence of the "vicious methods of the conduct of medical teaching as represented in preparatory medical schools." And it is fair to say that many were of the same opinion. In view of this hypothesis, and of the fact that since the time of the report on which it was based up to the final one of five years later, and notwithstanding that distinct improvement in the administration and the teaching in medical colleges had taken place, and broader laboratory avenues of well-known scientific outcome were in operation, still it does not appear that a sufficient rising in the tide of advancement was reached to influence satisfactorily the inclination of munificent givers. For, according to the report of 1903-4, each of the 7,400 theological students of 1904 had the income of $3,031 provided for his instruction, and each of the 27,000 medical students of that year had the income of $54 provided for the same purpose, thus showing a gain over the previous report in favor of the theological student of $781 per capita, and a loss to the medical student of $29 per capita, for teaching purposes.

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ENDOWMENTS.

Substantially the benefit of $22,500,000 was available for the purposes of theological education as against the benefit of $1,450,000 for medical educational use at the time of the report of 1903. At this time, of the 153 theological schools 77 report endowments and 76 report no endowments. And of the 152 medical schools 19 report endowments and 133 report no endowments. Also five of the theological schools had endowments varying in amount from $853,000 to $1,525,388 each. Now, more than ever, are we impressed with the force of another expression, "Help yourself and heaven will help you."

In view of this later increase in the difference of the incomes bestowed for direct educational purposes and under improved medical conditions it seems quite likely that opposing factors, more potent than first assigned, are extant. When, however, it shall happen that bountiful givers regard us in health as in acute affliction perhaps greater heed will be given to the wisdom of making larger educational gifts. Irreverent comment has hinted of another compelling influence, especially related to generous adult minds(embodying the notion that the hope and faith of celestial expectancy are more attractive than are the faith and outcome of terrestrial realization.

Whatever may be the reason for the continued paucity of medical endowment, I am not prepared to say, but I hope that substantial improvement will be secured through the convincing influence of beneficent subjective and objective lessons, patiently, discreetly and thoughtfully impressed by us on the public mind. Yet, confronting this hope, there appears an ominous specter pointing to the fact that only by laborious effort, chiefly supported by the medical profession, were the memory and brilliant services of the late Dr. Walter Reed meagerly characterized. Those who experienced the greatest blessings because of them gave the least to the care of those whom he loved most.

The simple, commonplace remark, "the promoting of friendly intercourse among American physicians," I regard as the most important announcement set forth in the opening declaration of the constitution of the association, looking to the "Promotion of

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the Science and Art of Medicine." For, without the stimulating and guiding support of professional good-fellowship in all that the term implies, discord and discredit are likely to delay or cripple the realization of this one great object in view.

THE JOURNAL.

I know of no agent so well fitted to contribute to the fostering of the growth and the diffusing of medical knowledge and the promoting of friendly intercourse among American physicians as rightly falls to the lot of *The Journal of the American Medical Association.* A journal with a weekly circulation of over 50,000 and accounted as the utterance of many more than this number of the organized medical profession of the country may well be regarded in things of professional concern as the voice of the multitude proclaiming its will. Therefore, it is important that the tone and wisdom of its speech be in accord with the judgment of the great majority of our profession. I am inclined to believe that when the pages of our journal are the forum of temperate and instructive discussion of the policies of common interest to our membership greater impetus will be given to just causes and a broader scope to fraternal comfort among American physicians. One, however, cannot be reminded of *The Journal* without being impressed by the creative ability, the abiding energy and overtaxed assent of the editor, the Secretary of this Association.

I am deeply impressed with the belief that at this time the greatest danger to continued harmonious unity in the Association lies ill-hidden in the constituted expression, "to safeguard the material interests of the medical profession." It requires no special discriminating sense to foresee the devious interpretations which eager desire might willingly give to the phraseology of this declaration. Fortunately, however, no rendering of the language of this expression can be properly entertained which conflicts with that of the antecedent one, "the promotion of friendly intercourse among American physicians." However this may be, the following suggestive lines of Froude should not be over-

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looked: "Where all are selfish the sage is no better than the fool, and only rather more dangerous."

THE WAR AGAINST DISEASE.

The genuine products of completed organization of the medical profession are of infinite importance to the well-being of the country. The potent factors of common prosperity will be encouraged and protected; the hearts and homes of the well-to-do and the hopes and hovels of the needy will each reflect, in joyous ways, the benefits of co-operative action in fixing the nature, overcoming the causes and lessening the burdens of disease. The war now under way against cancer and tuberculosis, two of the insatiable inflictions of humanity, can, along with that opposing ophthalmia, be waged with comprehensive rational designs and improved prospective results.

The broader the field of opportunity in this regard, and the greater the activity of the contest, the more bounteous will be the return and the greater a final victory. When, for instance, it is recalled that for unknown reasons the death-rate from cancer is slowly advancing in spite of intelligent, earnest opposition; that acquired tuberculosis yet adds 13 per cent to the total death-rate; that unrestrained ophthalmia causes over 25 per cent of the blindness from disease; that over 30 per cent of the school children of New York, and perhaps of other large cities, suffer from defective vision, and that in 75 per cent is their mentality impaired by causes yielding to curative measures of a simple and permanent nature, then, indeed, is the necessity for united action relating to control of human infliction emphatically demonstrated.

The alleviation and cure of such afflictions serve to lighten the burdens of public care, to lessen the tenantry of charitable and penal institutions and to lay the foundation of good citizenship.

A NATIONAL BOARD OF HEALTH.

The fact that communicable disease has no boundary restraints in the presence of unguarded human pursuits is quite as familiar to the lay as to the medical mind. Also that human indifference and human ignorance and established sectional state policy often

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contribute an unfortunate share to human distress is well known to the medical profession. It would seem wise, therefore, that interstate sanitary regulations should be established, thus affording even-handed opportunity of protecting interstate enterprise from the effects of concurrent disease. Duties of this nature and others of national sanitary importance can be properly met when an awakened sense of the need on the part of those controlling the affairs of the country shall invite the co-operation of our profession looking to the acquiring and preserving the best results, which wise statesmanship and wise sanitation can jointly secure.

A national board of health having in charge such things as properly fall under its consideration and action would be a national blessing of ever-increasing importance. But in this relation candor compels me to state that I find little encouragement for those of our profession who at the outset would demand a seat in the executive council at the head of the nation as an acknowledgment of professional capacity, or as a retainer for prospective service. Instead we and others laboring in mercy's cause should be willing to serve in allotted capacity as Jacob served for Rachel, with unostentatious patience, tinctured perhaps with cruel disappointment, but leaving the results of our labors as an earnest of our worth and of the reward which best befits it.

Not a little has been said in the near past regarding the possibility of securing national incorporation of the American Medical Association, with power to hold property and transact business anywhere in the United States. The gaining of such incorporation is no longer speculative, for within the last year several charters of similar scope to that framed by Judge Ray for us have been secured for other organizations. I am inclined, however, to hesitate in recommending a renewal of endeavor in this respect until assurance can be had of earnest, genuine effort on the part of all, looking to the securing of incorporation and also co-operation in the adjustment of the business matters essential to a completed consummation of the act. A policy which would contemplate the locating of the business affairs of the Association at Washington in the event of incorporation, I regard as hostile

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to the best interests of the profession and contributive to the impairment of fraternal peace.

MEDICAL LEGISLATION.

The enactment and enforcement of just medical laws is a matter of superlative importance. Fair and equitable relations, founded on uniform standards, should be established between the respective States regarding the requirements of medical education. Under this arrangement, fully qualified physicians going from one State to another would not be obliged to submit to annoying State Board scrutiny concerning fitness to practice medicine. Since no unusual professional attainments are necessary to meet the exigencies of practice in any State of the Union, but little difficulty should be experienced in establishing a grade of educational requirement, permitting of practice through reciprocal comity.

The unwelcome thought arises at this time that, in the absence of equitable State reciprocity, one or more States not blessed with first-class educational opportunities might endeavor to protect their own interests against the professional encroachments of the graduates of first-class medical schools by requirements to practice of such character as not to merit serious thought on the part of the faculties of highly reputable medical institutions. It is difficult, however, to conceive that this idea can be more than a passing fancy, for how a course of this kind could receive the sanction of good judgment is not easily understood. Relative to competent practitioners of long standing who may desire to change their State environment, a greater difficulty attends a proper adjustment of their situation. It seems to me, however, that common justice requires that a form of examination should be given in these instances, which in its scope is measured by practical methods consistent with the experience of the applicant, rather than by one of modern requirement. For I am quite certain that if a member of the teaching faculty of a modern medical school were unexpectedly to find himself outside the halls of his own institution, a creditable return through the enlightened channels prescribed by his catalogues for students, would be shad-

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owed with great doubt and probably attended with humiliating disaster.

MEDICAL EDUCATION.

Beneath this opinion lies a thought pregnant with important professional responsibility relating to all those who have to do with regulating the requirements to begin the study of medicine. Should it occur to them that ideals may not everywhere be needed and that the object might be to meet the requirements of the whole country—a country yet comparatively new in professional opportunities and rewards for ambitious young men in a great part of its area? Should it occur to them that the coming into the field of action of vast business enterprises has begotten corresponding opportunities with less preparatory drudgery and expense and by greater prospective rewards than generally attend the practice of medicine? Ought they to keep in mind that the increase in educational requirements above a certain point has not resulted, at least in New York State, in a corresponding increase in medicine of those of the highest qualifications, but instead their comparative numerical status (21 plus per cent) in this and in other common respects has remained practically unchanged for the last ten years? Is it not possible, therefore, that many worthy and able young men who are less favored than their fellows have sidestepped because of the comparative hardships imposed by educational requirements and the uncertain and delayed rewards that attend earnest endeavor in the medical profession?

Whether or not the standard of medical education should be raised in this country to equal that of the old world is a matter concerning which honest differences of opinion are earnestly pronounced. While no one can consistently contend that knowledge is not power, yet the adjustment of more than a requisite amount of knowledge in the practice of medicine, to be sparse occupancy of many broad areas of this country, is a matter which for some time to come may concern the stern power of economics more than the needs of ideal culture. Possibly, therefore, those who are blessed with commendable professional dignity and with pleasing remunerative environment might willingly pause for a

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time while giving thought to the demands for professional care in broad necessitous surroundings.

The analytic work being done by the Council of Medical Education is mercilessly disclosing the comparative *status* of the medical schools in this country to the discredit of many heretofore differently regarded. The active manner in which the labor is carried on under the chairmanship of Dr. Arthur D. Bevan is creditable to the committee and to the cause in hand. Inasmuch as the standard of suitable preparatory medical attainment depends more on the capacity of a faculty to impart knowledge and beget character than it does on the phraseology of the curriculum the outcome of the committee's efforts is being watched with solicitous interest by all concerned in honest standards of moral and medical qualifications.

Apropos of the importance that the faculties of medical schools should lead the way to higher station in professional ethical conduct, both by precept and example, I am prompted to say that there appears to be no doubt that uncanny business instincts are encroaching on the reciprocal vulgar ways characteristic of lay methods not a little on the sacred domain of professional propriety. I am of the opinion that trespasses of this kind are chiefly the outcome of acquisitive intentions based on delusive self-seeking desires. The remedy for the cure of this unprofessional propensity rests largely in the hands of the faculties of medical schools. They should inculcate a high sense of professional honor in those who come under their tutelage. Ample instruction of medical students in the tenets of moral philosophy, as applied to the practice of medicine, and substantial disapprobation of offending practitioners by their colleagues will, in my judgment, hasten the reduction of this evil to a minimum.

In this glorious country of ours, "the will of the people is the law of the land." And in this bearing it is needful that we should act with good sense concerning our *personnel* in all matters which are of special interest to the commonalty, so as not to encounter the adverse activity of popular desire. In this connection it is important to know that in the United States there are about 84,000,000 people, the great majority of whom are capable of

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satisfactorily judging of the practical things of life relating to themselves as they come into thought. Also in the United States there are about 112,000 physicians who are eligible to membership in the American Medical Association, but of which as yet little more than one-half are affiliated in any capacity with the organization. It logically follows, therefore, that a judicious estimate should be made of how the great majority of the 84,000,000 of people plus nearly half of our own calling would regard our intentions before venturing at all rather than prematurely to court defeat and corresponding loss of station. The question is *not* altogether what we think of ourselves and our causes, but the question is how we ourselves and our causes may be regarded by the people concerned and by their friends, to say nothing of the balance of our own profession. And, too, it should be kept in mind that it is not likely that general mutual accord will prevail in all matters of common interest which arise in organized bodies of men. In a humane profession appeals should be made to judgment, not to passion or prejudice. It is within the easy recollection of most of us that sturdy efforts were made by the united medical profession of a State in what was regarded to be a justifiable cause. Yet, as it appears, decided defeat was the outcome, because the majority of the interested people were not in harmony with the contention. This suggestive lesson should not pass unheeded, if experience and good judgment are to become available assets in the conduct of the affairs of medical organization.

THE NEED OF HONEST DRUGS.

It is written that Oliver Cromwell, while fording a river with his army to attack the enemy, exclaimed, "Put your trust in God, but mind to keep your powder dry!" No less determined than Cromwell was, do many physicians now feel on account of the fact that their figurative powder (drugs) is quite apt to be worse than wet, being alarmingly defective in quality and fickle in strength. As an illustration of these facts, no evidence more convincing can be presented than that of the Health Deprtment of New York City. This efficient department has for some time labored with discreet energy and with astounding results in this

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heretofore comparatively untilled field of interrogative scrutiny. That the crude drugs and standard preparations approved by the United States Pharmacopeia and prepared and exploited by reputable pharmacists should, in all instances, be found trustworthy admits of no denial.

It appears, however, from the report of the Board of Health of New York City, on the analytic findings incident to the examination of crude drugs, tinctures, fluid extracts, etc., as compared with corresponding standards adopted in the United States Pharmacopeia, that reputable pharmacists have, because of commercial indifference or studied intention, not infrequenly contributed to therapeutic misfortune through the quality and strength of their drugs. I will call your attention to only a few illustrations which are an emphatic earnest of the need of general scrutiny of the pharmaceutical part of our therapeutic armamentarium.

It is a matter of general knowledge that aconite is a drug of potent nature and in compartively common use. Of this drug five of the thirteen samples analyzed were of the tincture and fluid extract of the root. Of the three specimens of the tincture one had 9 per cent more, and of the remaining two six per cent and 20 per cent, respectively, less of aconitin in than the standard requires. The two samples of extract of the root had 13 1-2 per cent and 25 1-2 per cent, respectively, more aconitin in than is required. The remaining six samples were of the powdered root which in no instance was sufficiently abnormal to call for admonition. The samples of belladonna showed, respectively, from 35 per cent to 45 per cent less of mydriatic alkaloids in the powdered extract of the leaves, 11 1-2 per cent less in the fluid exract of the root, 17 per cent more in the tincture of the leaves and 47 1-2 per cent in the fluid etract of the leaves than is required by the United States Pharmacopeia. Powdered nux vomica was found to be comparatively worthless, but in the tincture and fluid extract was revealed an excess of strychnin above the required standard of 19 per cent and 17 per cent, respectively. In the tincture of opium was found, of morphin 7 per cent to 13 per cent more than the accepted standard of composition.

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In 1-100 gr. tablet triturate of nitroglycerin was discovered only 1-1600 of a grain of the drug. It is said that this preparation of nitroglycerin was known by the manufacturers to be unreliable and, therefore, should not have been exploited at all or in a guarded manner. It is not difficult to foresee from the failing to secure proper response from the use of these or other tablets of uncertain strength that the substitution therefor of a fresh solution of the drug might result unfortunately, especially if the dose of the fresh preparation were of the same amount as was that of the tablet last given. I have in mind an instance of this kind in which the use of a fresh solution of strychnin caused a fatal result.

It further appears that of the first sixty-one samples of drugs examined by the health department, all of which "articles are of exceptional importance, most of them potent poisons and all are represented by definite chemical standards in the Pharmacopeia," only about 28 per cent of the whole number was considered good and 16 per cent were so bad as to justify legal action. It is proper to say that the majority of the manufacturers, recognizing the awkward position in which they were placed, with a spirit of yielding opposition complied with the reformatory demands of the health department. This list of producers is small in numbers compared with those who are engaged in similar business in the United States, and, no doubt, present as favorable a picture of this class of the drug evil as can be drawn.

Nor is the aforegoing distress the only torment in pharmacy with which the medical profession has to contend. The idealized, savory products of pharmacy with which the market is cloyed are often quite as fickle in their nature and virtues as was a certain ancient queen of the Nile. Discreditable business thrift supplemented by co-operative professional contentment and convenient indifference, patronized by confiding and credulous people, yields princely returns for the diminutive cash and equivocal integrity invested in it.

Not all of those, however, engaged in the pharmacal trade are unworthy of the trust and confidence given to men in other avenues of business. Very many, indeed, thus engaged are as sincere and trustworthy in their business affairs as are the best of

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those in other undertakings. Therefore, the old and revered principle of common justice, while emphasizing the fact that every person should be regarded as being honest until the contrary is proven, should be kept in mind and action. Consequently, in our conduct of matters imbued with professional or business virtues, the resolution should be to estimate uprightness of character by the tenets of common justice, and not by preconceived notions hostile to the principles of established equity. Purposes thus graciously fortified command respect, and gain in strength because of opposition. The reverse, however, will beget distrustful thought and may finally cause defeat. In this recital I cannot overcome the belief that we ourselves contribute a major share to the inception and success of many medicinal ventures by our indifference or ignorance relating to savory prescribing and also by our thoughtless employment of proprietary medicines. Here, too, is a chance for medical teachers to instill proper notions regarding consistent ethical and therapeutic refinements.

When John Dryden wrote, "Virtue is her own reward," he expressed a sentiment in keeping with the self-sacrificing spirit characteristic of the members of the Council on Pharmacy and Chemistry of the American Medical Association. I am creditably informed that these gentlemen are serving the profession and the people in this labor without the expectation of vulgar reward or the anticipation of special favor. I desire to commend their motives, approve of their work, and bespeak on the part of the profession an earnest support of all wise conclusions. Those who labor in a just cause without stipend are deserving of great praise; those, however, who serve for pay can only expect approbation.

But little less important than the preceding, in some respects, would be the careful scientific consideration of the therapeutic value of the abundant springs of our country. There is much, indeed, of special significance regarding their popular use which might well be garnered and put on a sound basis. A scientific co-operation with those who are in charge of certain baths possessed of traditional specific value might readily guide to improved conditions of significant importance to all those who seek

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relief. A country as rich as ours in these spontaneous endowments can well afford, in proper ways, to court the attention and support of the afflicted and to the decided advantages of all concerned.

THE MEDICAL PROFESSION IN CIVIC LIFE.

The sincere belief, on my part, that the outcome of professional governing policies of common interest in our affairs are practically alike in county or State prompted me, in a recent parting address to the united medical profession of the State of New York, to say: "The organization of the medical profession here and everywhere throughout the country contemplates the realization of more than the scientific advantages arising from personal contact and local co-operative thought. It should be regarded as an earnest that the medical profession intends to take an active and controlling part, if possible, in those affairs of civic life which relate to the well-being of the body politic. There should be no question regarding the status of the medical profession in all matters relating to the securing of pure food, pure drugs and wise public sanitation." Also it was said: "It would be sadly amiss, indeed, were I not to admonish you at this time, the opening of a united career, of the grave perils begotten by a spirit of paternalism which not infrequently is a pernicious by-product of organized power. The seductive and aggressive influence of this spirit often usurps and may inhibit that nobler, more enduring and beneficent spirit characteristic of common manhood and professional brotherhood. And it should not be forgotten that the greater and more extended is the membership of a fraternal body the greater and more extended are self-seeking desires apt to be. Consequently, the longer the chain of affiliation is the weaker it may become, for, as you already understand, 'no chain is stronger than its weakest link.' I pause to inquire, Is there any good reason to doubt that the medical organization of the nation might not respond to similar influences? Let us, however, cherish the belief that wise discretion fittingly stimulated by just conceptions of fraternal spirit will guide us securely along the

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pathway of increasing professional attainment and good fellowship to the end of useful life."

And, finally, when by the aid of Divine Providence, the medical profession of the United States shall have been made into "one compact organization" and impelled in dutiful desires only by the highest motives of professional purpose and of public welfare, no enlightened opposition will oppose its desires nor will irrational outcry, nor vagrant motives, find patient listeners or available foothold in the councils of the organization or in those concerned in the requirements begetting of public confidence and respect.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

A Method of Reducing Old Colles' Fractures—Stiffness Following Apparent Contusions of the Elbow Joint.

Clarence A. McWilliams considers the possibility of improving the position of the fragments in cases of Colles' fractures which have gone for some time unrecognized, and have become consolidated in bad position. In some cases disability is slight and it is better to let things alone. In others it seems necessary to do something to improve matters. The author uses for refracturing the bones a large engineer's monkey wrench with the blades well padded. This is used to immodilize the upper fragment, resting against the projecting edge of the lower fragment. Thus a fracture in the line of the original injury may be produced with the expenditure of very little force. There is no strain on the structures of the wrist, and the injury to the tendons is very slight. Traumata at the eldow joint, which are treated for sprains sometimes develop stiffness later, on account of the formation of new bone within the joint, as a result of a fragment of periosteum getting into the joint and producing bone, which is so placed as to be between the ends of the bones. Usually forced persistent passive motions will crowd away the fragment of bone to the side of the joint so that it does not interfere with motion.—*Medical Record.*

To Prevent Nasal Obstruction During Anesthesia.

Dr. G. M. Cushing, Chicago, calls attention (*Surg., Gynec. and Obst.*, February, 1907) to cases that take anesthetics badly because of nasal obstruction. In such cases an ordinary wire hairpin, bent in the form of the letter M, inserted into the nasal orifice, so that the central part rests against the septum while the

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lateral wings rest one in each ala, holding it open, allows respiration to go on with perfect freedom. The method of bending the hairpin or wise prevents it being lost in the nasal cavity.—*Virginia Medical Semi-Monthly.*

MEDICAL

Pus Tubes in the Male.

Wm. T. Belfield says that pus infection in the seminal tube of the male is quite as frequent as in the Fallopian tube in the female. It is frequently not recognized, since pyuria, frequent and painful micturition, and retention of urine are symptoms common to it and other urinary conditions. Infections result from the gonococcus, pyogenic bacteria, and the tubercle bacillus. When the seminal vesicle is invaded the complex of symptoms causes a diagnosis of prostatic abscess in most cases, while they are rather due to abcess in the seminal vesicles. Stricture of the bulbous urethra gives a picture that is usually mistaken for gonorrhea, although it is purely the result of pyogenic bacteria. In men over forty years old, pus in the urine is ascribed to prostatic hypertrophy. The author advises simple incision with a cautery knife from the rectum to relieve pus tubes. A still simpler operation, and one that can be done in the office, is that of opening the vas deferens, stitching the cut edges to the skin, and injecting through a curved hypodermic needle any chosen solution. The liquid traverses the vas and ampulla and enters the seminal vesicle. Daily injections are made until the infection is over, when the fistula can be closen.—*Medical Record.*

Acid Intoxication or Acidosis—A Factor in Disease.

Eugene S. Talbot says that many individuals have an abnormal degree of urinary acidity which results in destruction of the alveolar processes. Colds, headache, backache and important lesions during pregnancy result from the same condition as well as serious kidney and liver diseases. Here is a positive index for prophylaxis, as well as for careful examinations of urinary

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acidty by the surgeon before anestehsia. Indican, too, should be sought for. The treatment of these two symptoms, excessive acid and indican in the urine, may restore health without the use of drugs to counteract the other present. The author has instituted careful examination for abnormal acidity in diabetes, tabes, and other diseases. He believes that the so-called pyorrhoea alveolaris is the results of faults of general nutrition, kindred to acidity. The acids are eliminated by the gums as well as other organs, and in this elimination injuries the enamel of the teeth. Uric acid is not in excess in many diseases, according to modern researches. Fruit acids may be taken in excess and produce temporary hyperacidity which is aliminated by the gums. Lessened blood alkalinity affects the whole alveolar process, setting up inflammation of the coats of the arterioles and in the tooth pulp, ending in endarteritis obliterans, arteriosclerosis, and nerve degeneration. Disease of the terminal arteries and nerves causes absorption of the bone. It has been shown that a high degree of acidity exists in ordinary colds, eruptive diseases, pneumonia, and typhoid as well as in many other diseases—*Medical Record.*

OBSTETRICAL

Pathology of Gonorrhea in Women.

H. C. Coe tells us that the intact mucosa of the vagina is rarely infected by the gonococcus. It may enter the cervix at once, or attack the glands of Bartholin, or vulva, but bladder infections are rare. The gonococci are aided by their tonic products in producing the changes seen. Latent gonorrhea is frequent. The muscular walls of the uterus may be invaded and lymphatic infection of it occasionally occur. Gonorrheal cellulitis and rheumatism are rare in the woman. The stroma of the ovary is probably not primarily affected by way of the lymph channels. Acute oophoritis is due to mixed infection, all sorts of microorganisms being found in the secretions. Irrigation and drainage are generally not needed in tube cases, since the pus is sterile, or the infected point is away from the penetration of the injection.

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Gonorrheal infection when seen by the surgeon is generally of long standing. Appendicitis is often combined with tuboovarian disease. As to cure, under rest and hot douches with tampons a symptomatic cure may be obtained, although restoration of tissues to the normal is impossible. Sterility is apt to be the fault of azoospermia in the male.—*Medical Record.*

Instrumental Premature Labor in Practice.

O. Polano (*Munch. Med. Woch.*, September, 1906) speaks of the experience of the clinic in Wurtzburg with induction in labor. Among 1,952 cases of labor, with 119 contracted pelvis, there have been 18 cases of induction of premature labor. He gives the comparative value of the three methods—bougies, rupture of the membranes, and metreurysis. The sterilized bougie, introduced between the membranes and the uterus was most frequently used, but is very uncertain, after two weeks trial having proven useless. There is danger of infection and hemorrhage from separation of the placenta. Rupture of the membranes is sure in the majority of cases, but fails in some. It is relatively slow, taking from 77 to 80 hours to produce the desired effect. This delay is hard for the operator. Introduction of an inflated rubber baloon between the membranes and the uterus is the best method according to the author's views. The baloon is sterilized, introduced with forceps, and then inflated.

In the Wurtzberg hospital the operation is done only for contracted pelvis, or for general diseases threatening the life of the mother. In order to obtain natural pains quickly it is best to use alternate pressure and relaxation, by letting the contents of the bag escape. When the baloon is forced out the uterus may reclose, or there may be an entire failure of contractions. After any one of these methods the uterus will usually expel the child without assistance after the membranes have been ruptured. The author believes that the best method is far better than those in which the patient must lie for house and days waiting for delivery. —*Amer. Jour. of Obstet.*, January, 1907.

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

INDEX MEDICUS—SECOND SERIES.

The *Index Medicus* was established in 1879, under the editorship of Dr. John S. Billings and Dr. Robert Fletcher, and was discontinued in 1899. The present series began with the number for January, 1903. Each number of the *Index* presents the literature of the month named on its cover and is issued as early as possible in the succeeding month, time being allowed for the arrival of foreign journals. The present editors are Robert Fletcher, M.D., and Fielding H. Garrison, M.D.

This publication consists of the titles in full of the books, pamphlets, these contributions to co-operative works and original articles in journals, transactions of medical and scientific societies, and the like, arranged under subject-headings. The titles in certain languages, as Russian, Polish, Swedish, Danish, Finnish, Hungarian, Bohemian, Roumanian, and Japanese, are translated into English.

The *Index Medicus* offers an extensive monthly bibliography especially to those in charge of public and private sanitation, and it is desired to call the attention of such officials to the merits and practical value of this publication. Every month, among the subdivisions under the class of Public Hygiene appear articles on Sewerage, Drainage, Water Supply, Inspection of Food and Drugs, Disposal of Dead, and Hygiene of Habitations, Occupations, Persons, Schools. The subject of Medical Charities, Medical Education and Schools, and Medical Jurisprudence are also included.

A table of contents accompanies each number, and a few

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months after the completion of each volue an "Annual Index of Authors and Subjects" is issued. The subject part of this annual index is elaborately sub-divided, the classification closely resembling that of the Index Catalogue of the Library of the Surgeon General's Office, U. S. Army.

The volume for 1905 contains 1241 pages and the index to the volume, 208 pages, the latter in double and triple columns.

Upon request a sample copy of the *Index Medicus* will be forwarded to any address.

The subscription price of the *Index Medicus* (to be paid in advance) is five dollars a year in the United State, Canada, and Mexico, with 60 cents additional for postage to other countries.

Subscribers are requested to remit by money order or New York exchange.

Communications relative to subscriptions should be addressed: Carnegie Institution of Washington, Washington, D. C.

Communications concerning the bibliography should be sent to: Editor of *Index Medicus*, Army Medical Museum, Washington, D. C.

No numbers of the First Series can be supplied, but copies of later volumes and numbers are available.

The subscription price of the last five volumes of the First Series of the *Index Medicus* was $25 a year. In setting the annual price of the present series at $5, though it bears no proportion to the cost of production, the Carnegie Institution of Washington anticipated that physicians, health officers, librarians and statisticans would very generally subscribe for the journal. This expectation has not been realized.

Unless it appears that the *Index Medicus* is of greater service to the medical profession and can help to support itself to a greater extent than in the past, it may become advisable to discontinue its publication.

The *London Lancet* is mourning the loss of its long time editor, Mr. Thomas Henry Wakley, a son of the Thomas Wakley who founded the *Lancet*. Although the recently deceased editor had reached the age of eighty-six he was up to the last active in the

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management of the journal. A brother, James Wakley, was for a long time one of the editors and the son succeeds to the editorship, making the fourth Wakley covering the whole life of the *Lancet*. The writer was fortunate enough to have had a personal acquaintance with the late deceased Thomas Henry Wakley, and found him a very agreeable gentleman and just such a man as you would expect to find at the head of the staid, staunch and conservative *Lancet*.

TREASURY DEPARTMENT.

BUREAU OF PUBLIC HEALTH AND MARINE-HOSPITAL SERVICE.

Washington, D. C., May 17, 1907.

A board of officers will be convened to meet at the Bureau of Public Health and Marine-Hospital Service, 3 B street SE., Washington, D. C., Monday, July 15, 1907, at 10 o'clock a. m., for the purpose of examining candidates for admission to the grade of assistant surgeon in the Public Health and Marine-Hospital Service.

Candidates must be between 22 and 30 years of age, graduates of a reputable medical college, and must furnish testimonials from responsible persons as to their professional and moral character.

The following is the usual order of the examinations: 1, physical; 2, oral; 3, written; 4, clinical.

In addition to the physical examination, candidates are required to certify that they believe themselves free from any ailment which would disquality them from service in any climate.

The examinations are chiefly in writing, and begin with a short autobiography of the candidate. The remainder of the written exercise consists in examination of the various branches of medicine, surgery, and hygiene.

The oral examinations includes subjects of preliminary education, history, literature, and natural sciences.

The clinical examination is conducted at a hospital, and when practicable, candidates are required to perform surgical operations on a cadaver.

Successful candidates will be numbered according to their

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attainments on examination, and will be commissioned in the same order as vacancies occur.

Upon appointment the young officers are, as a rule, first assigned to duty at one of the large hospitals, as at Boston, New York, New Orleans, Chicago, or San Francisco.

After five years' service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon.

Promotion to the grade of surgeon is made according to seniority, and after due examination as vacancies occur in that grade.

Assistant surgeons receive $1,600, passed assistant surgeons, $2,000, and surgeons $2,500 a year. When quarters are not provided, commutation at the rate of thirty, forty and fifty dollars a month, according to grade, is allowed.

All grades above that of assistant surgeon receive longevity pay, ten per cent. in addition to the regular salary for every five years' service up to forty per cent. after twenty years' service.

The tenure of office is permanent. Officers traveling under orders are allowed actual expenses.

For further information, or for invitation to appear before the board of examiners, address "Surgeon-General, Public Health and Marine-Hospital Service, Washington, D. C."

Resolutions of the Council of Pharmacy and Chemistry, A. M. A.

We are in receipt of the following resolutions, which tends to show the trend of efforts being put forth to improve medicinal preparations, and which will prove of interest to our readers:

Chicago, June 20, 1907.

Dear Doctor:

At the Atlantic City Session of the American Medical Association the following resolutions, regarding the work of the Council on Pharmacy and Chemistry, were presented by the Reference Committee on Reports of Officers and were unanimously adopted by the House of Delegates:

Whereas, The Council on Pharmacy and Chemistry, after ex-

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amining many hundreds of preparations, has officially announced its approval of a large number of such preparations; and

WHEREAS, We believe that the editors of many medical journals in this country, both official organs of State Associations and privately owned journals, are desirous of co-operating in the work of freeing the medical profession from the nostrum control; therefore, be it

Resolved, That this Association most earnestly requests all medical journals to refuse to aid in promoting the sale of preparations which have not been approved by the Council, by refusing advertising space to such preparations; and be it further

Resolved, That we most earnestly request the moral and financial support of our members for those medical journals, whether privately owned or controlled by medical organizations, which disregard commercialism and stand firm for honest and right dealing, thus sustaining the Council in its greatest work for the medical profession.

In accordance with the instructions of the House of Delegates, I am sending you a copy of these resolutions in the hope that the American Medical Association and its Council on Pharmacy and Chemistry may have your support and co-operation in this most important work. I am also sending you a list of the preparations that have thus far been approved by the Council, as well as some articles reprinted from The Journal, which will, I hope, be of interest to you. Very truly yours,

GEORGE H. SIMMONS,
General Secretary.

The *Western Canada Medical Journal,* of Winnepeg, Manitoba, is one of the new claimants of the attention of the medical world. George Osborne Hughes, M.D., is editor-in-chief, and Harry Morell, M.D., is managing editor. The table of contents and the mechanical part of the journal do credit to the editors and publishers. To this section of the city whose board of trade adjourns to celebrates the fourth of July, we extend a most hearty and brotherly greeting.

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Reviews and Book Notices

Modern Medicine.—Its Theory and Practice. In Original Contributions by American and Foreign Authors. Edited by William Osler, M. D., Regius Professor of Medicine in Oxford University, England; formerly Professor of Medicine in Johns Hopkins University, Baltimore; in the University of Pennsylvania, Philadelphia, and in McGill University, Montreal. Assisted by Thomas McCrea, M. D., Associate Professor of Medicine and Clinical Therapeutics in Johns Hopkins University, Baltimore. In seven octavo volumes of about 1,000 pages each; illustrated. Volume I just ready. Price per volume, cloth, $6, net; leather, $7, net; half morocco, $7.50, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1907-1908.

This magnificent work, under the able editorship of Wm. Osler, M. D., appears in its first volume, to be followed by six others, the design being to cover the whole field of medicine in a publication that has no equal in thoroughness, scientific research and comprehensiveness. The undertaking has been stupendous and we feel sure the undertaking will be liberally applauded by the entire profession. As a work of general reference it will have no equal. Vol. I contains a number of thoroughly practical clinical articles as well as carefully elaborated subjects of the greatest interest to the physician. It is a work for every physician who would keep qualified for the full discharge of duties attaching to the practice of medicine.

Manual of Operative Surgery.—By John Fairbairn Binnie, A. M., C. M. (Aberdeen), Professor of Surgery, Kansas State University, Kansas City, Fellow of the American Surgical Association; Membre De La Societe Internationale De Chirurgie. Third Edition, Revised and Enlarged, with 678 Illustrations; a Number of Which are Printed in Colors. P. Blakiston's Son & Co., 1012 Walnut Street, 1907.

We acknowledge receipt of the 3d edition of this important manual. It is seldom that a book meets the daily wants of the practitioner so completely as this. It is copiously illustrated throughout, and these with the clear, concise text enable the reader to grasp operative details almost at a glance. The manual is an excellent working manual for the busy practitioner and

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should become very popular with the profession. The book is compact and provided with flexible leather cover, which adds to the attractiveness as well as usefulness of the volume. We rather regret that the author his seen fit to exclude amputations, ligations and excisions as such an addition would have added materially to the value of the work.

The Practitioner's Library.—The Practice of Gynecology in Original Contributions by American Authors. Edited by J. Wesley Bovee, M. D., Professor of Gynecology, George Washington University, Washington, D. C. Illustrated with 382 Engravings and 60 Full-Page Plates. Lea Brothers & Co., Philadelphia and New York.

This is one of three companion volumes on the several subjects of Gynecology, Obstetrics and Pediatrics, the two latter having appeared previously and noticed in this journal. Too much commendation cannot be bestowed upon these excellent books—they are all that the publishers claim for them. This number of the set is especially good. The editor has presented in it a practical treatise collaborated by a number of distinguished writers on the diseases of the generative organs of women and on those of neighboring organs, the urinary system and rectum. As the editor says in his preface, it has been his object to make the book eminently practical and to make it so due consideration has been given to conditions actually met by the gynecologist in his daily work. The names of the contributors to this volume are J. Wesley Bovee, M. D.; J. Riddle Goffe, Ph. M., M. D.; G. Brown Miller, B. S., M. D.; Geo. H. Noble, M. D.; Benjamin R. Schenck, A. B., M. D.; Thomas J. Watkins, A. M., M. D.; X. O. Werder, M. D.

Practical Gynecology.—A Comprehensive Text-Book for Students and Physicians, by E. E. Montgomery, M. D., LL. D., Professor of Gynecology, Jefferson Medical College; Gynecologist to the Jefferson Medical College and St. Joseph's Hospitals; Consulting Gynecologist to the Philadelphia Lying-in Charity and The Kensington Hospital for Women. Third Revised Edition. With 574 Illustrations, the Greater Number of Which Have Been Drawn and Engraved Specially for this

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Work, for the Most Part from Original Sources. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. 1907.

The appearance of this book in its 3d edition indicates the esteem in which it is held by the gynecological branch of the profession. It is a scholarly presentation of this progressive department of the science of medicine, with clear text and ample illustrations. The book presents the subject in the most logical, comprehensive and easily accessible form, and is to be recommended as a most excellent text-book upon gynecology.

Progressive Medicine.—A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in The Jefferson Medical College of Philadelphia; Physician to The Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in The University of Pennsylvania; Member of The Association of American Physicians, etc. Assisted by H. R. M. Landis, M. D., Visiting Physician to The Tuberculosis Department of The Philadelphia Hospital, to the White Haven Sanatarium and the Phipps Institute; Demonstrator of Clinical Medicine in the Jefferson Medical College. Vol. II. June, 1907. Hernia—Surgery of the Abdomen, Exclusive of Hernia—Gynecology—Diseases of the Blood. Diathetic and Metabolic Diseases. Diseases of the Spleen, Thyroid Gland, and Lymphatic System—Ophthalmology. Lea Brothers & Co., Philadelphia and New York. 1907.

The June issue of this excellent quarterly is before us, and, like all of its predecessors, is replete with valuable contributions on improvements and advancements in the practice of medicine and surgery. The contributors to this volume are John G. Clark, M. D.; Wm. B. Coley, M. D.; Edward Milton Foote, M. D.; Edward Jackson, M. D.; and Alfred Stengel, M. D. The subjects treated of are Hernia, Surgery of the Abdomen, Exclusive of Hernia—Gynecology. Diseases of the Blood. Diathetic and Metabolic Diseases. Diseases of the Spleen, Thyroid Gland and Lymphatic System—Ophthalmology. We can conscientiously recommend this publication to practitioners as a most valuable serial, furnishing quarterly an exhaustive exposition of new theories, new developments and new and well-tried therapeutics as presented to the profession by searchers after scientific truths in all parts of the world.

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Publisher's Department

WHAT IS THE MORAL TO THIS INCIDENT?

Dr. X enjoys the largest general practice uptown. His large automobile is always on the go. He paid me a visit this afternoon. He was in the neighborhood, he said, and he thought he would drop in and make the acquaintance of the editor of the "brightest and most interesting medical journal published." He evinced some interest in the environment of the C. & G. Office. He noticed a large number—over two thousand—of different journals of the current year, nearly arranged in piles. "You read all of them?" "Yes." "Where do you get the time?" "You can get the time for anything, if you really want to." "Well, I can't. All I read is the J. A. M. A. and the Critic and Guide. I think they are the best journals published. And you and Dr. Simmons deserve a great deal of credit for the work you are doing with reference to patent medicines and proprietary nostrums. Great work. Time the physician's eyes were opened." Here he coughed and continued: "Would you please let me have a swallow of water. I have a little cold." The office boy brought a glass of water. Dr. X took out a tablet from a box in his vest pocket and swallowed it, washing it down with the water. The tablet was an antikamnia and codeine tablet.

I said nothing.

A life subscription to the reader who will point out the best moral of this incident.— *Critic and Guide,* May 1907.

THE MORAL.

On page eight of the January, 1907, *Critic and Guide*, appears the following editorial with which, no doubt, Dr. X fully agrees:

"When a patient comes to consult me and pays me a fee, then my sole sacred duty is towards that patient and towards nobody else. And I am going to use on him and prescribe for him whatever I consider most useful for him, regardless of all other considerations. Whether the preparation is trade-marked or not, whether it has a fanciful name or not, whether it has a circular

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around the bottle or not, whether the druggist makes 50 or only five per cent profit on it—for all of these things the patient does not care a picayune; and neither do I."

THE NURSING MOTHER.

The extra burden which a nursing mother has to bear, often places a greater tax on her strength and vitality than she can successfully meet. Rational treatment aims at an increase of her vital physiological functions, and a corresponding increase in her physical strength.

No remedy has a more positive value for this purpose than Gray's Glycerine Tonic Comp., and to many a physician it is the one tonic that meets every requirement in such conditions, as it is not only remarkably effective, but has no contra-indications.

THE PASSING OF WINTER.

With the passing of winter many an individual without being actually sick is still weak and debilitated, tiring easily, with greater or less susceptibility to every changing wind. The intelligent physician promptly overcomes this condition by suitable medication, and no more efficient tonic can be employed, than the well known Gray's Glycerine Tonic Comp.

In prescribing the products of Manufacturing Pharmacists, we should be guided to a great extent by the business standing of the manufacturers. No other house in the South or West has a better reputation for strict integrity than the Robinson-Pettet Company, Louisville, Ky. We do not hesitate to recommend the preparations advertised by them in this issue.

"Robinson's Lime Juice and Pepsin" is an excellent remedy in the gastric derangements particularly prevalent at this season. It is superior as a digestive agent to many other similar goods. (See page —, this issue.) See remarks on their Arom. Fluid Pepsin also.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. JULY, 1907. No. 7

Original Communications

REPORT OF SURGICAL OPERATIONS AT THE PRIVATE INFIRMARY OF DRS. CHARLES S. AND SAMUEL S. BRIGGS, DURING ITS SIXTEENTH SEASON, FROM SEPTEMBER 10, 1906, TO AUGUST 1, 1907.

REPORTED BY J. E. BELL, M. D., NASHVILLE, TENN.

The sixteenth season of this institution will close August 1, 1907, and the next will begin September 10, 1907. The number of patients treated has been about the average. The surgical operations performed have covered a wide range, embracing almost every procedure that falls to the surgeon's lot and the results have been in the fullest accord with the most improved achievements of modern surgery.

In this report only cases requiring operative treatment have been presented, but minor operations with the exception of those presenting unusual features have been omitted. The anæsthetic most frequently used was chloroform, though in cases in which the anæsthesia was apt to be prolonged and in patients in whom this anæsthetic was contra indicated, the A. C. E. mixture was employed. Ether alone was not administered one time. In a few instances the administration of the anæsthetic was preceded

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by a few inhalations of ethyl chloride and invariably with good effect. Nausea after anæsthesia, in spite of every means used to prevent, has been too commonly the rule and it is to be hoped that in the near future something will be found to prevent this troublesome complication.

The drop method of anæsthesia with Esmarchs chloroform mask has been the method invariably used. Dr. J. E. Bell has been the anæsthetist, though W. T. Briggs has in numerous cases acted in that capacity. The catgut used has been prepared after the method of Claudius, by the head nurse, Miss M. M. Sproull, who has also had in hand the preparation of all the dressings and sterilization.

The number of wound accidents has been small and the process of suppuration in wounds rare. The number of cases treated in all was nearly one hundred and eighty, in which number there were, as will be seen in the reports, four deaths. One death from suppurative appendicitis, one from surgical kidney following lithotomy, and one from convulsions following operation for spina bifida. The fourth death occurred in a patient undergoing preparatory treatment for an operation, and was due to tubercular peritonitis.

Case No. I. *Internal Urethrotomy for Stricture.*—G. W. S., æt. 58 years, Decatur, Ala. Admitted September 10. The patient had been troubled for some months with cystitis and painful micturition. He had suffered several times from complete retention and had been relieved by catheterism after a good deal of difficulty. The day after admission he was examined under local anæsthesia and two strictures disclosed, one somewhat anterior to the membranous urethra, the other in the pendulous urethra. These were both divided with Otis urethrotome and No.'s 28 and 30 sounds introduced. The prostate gland was not found materially enlarged. The subsequent treatment consisted in the every other day introduction of sounds and daily irrigation of the bladder with boracic acid solution. Improvement was satisfactory and the patient was dismissed October 6.

Case No. II. *Fracture of Ossa Nasi and of Humerus just above Elbow.*—Miss S. W. G., æt. 26, Pembroke, Ky., entered

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Infirmary September 13, 1906, suffering from the effects of a fall down a flight of steps. As a result she sustained a slight fracture of the distal ends of the nasal bones, a separation of the cartilage from these bones, an oblique wound an inch and a half long, extending down to the osseo-cartilaginous junction. The depression had been slight in degree and the wound had been nicely sutured and dressed by a home physician. On her arrival the sutures were removed, and the wound found nearly healed. Means were used to correct the deformity, lateral supports of gauze compresses employed on each side, antiseptic nasal douches ordered and the arm put up in posterior angular perforated metal splint. The case progressed rapidly to recovery; the deformity of the nose on dismissal being perceptible only by a slight lateral deviation to the right. Passive motion of the elbow was resorted to every day, and the splint removed sometime after she went home. The patient was dismissed September 19.

Case No. IV. *Stones in the Bladder; Medio-Bilateral Lithotomy.*—B. L., æt. 22 months, infant son of J. F. L., Nashville, Tenn. Admitted September 14, 1906. This patient had been troubled since birth with vesical symptoms, tenesmus, prolapsus recti, painful micturition and occasional hæmaturia. Under chloroform anæsthesia the stone searcher was used and the presence of calculus demonstrated. After some preparatory treatment, on September 16, the patient was anæsthetized with chloroform and medio-bilateral lithotomy performed as follows: Incision was made by puncture in the raphe of the perineum and the point of the knife made to open the membranous urethra on the groove of the staff. Through this opening the cystotome was carried along the groove into the bladder and withdrawn so as to divide the deep parts bilaterally to the extent of probably half an inch. The surgeons index finger was then passed along the staff into the bladder and the parts thoroughly dilated and the stone located. The deeper parts, however, had not been divided well by the cystotome and to permit of the introduction of the finger, use had to be made of a probe pointed bistoury. Forceps were passed along the finger into the bladder and the calculus seized and

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withdrawn. After removal of one stone, a second one smaller in size than the first was detected and removed. There was very little hemorrhage, but as a precaution a small tube was carried into the bladder through the perineal wound and a loose packing of gauze inserted. The progress of the patient was in every way satisfactory, and the case was dismissed entirely cured September 29. The stones were ovoid in shape, oxalate of lime in composition, and weighed, the larger one 50 grains, the smaller one 12 grains.

Case No. VI. *Punctured Fracture of the Skull: Trephining.* —J. F. D., æt. 33 years. Admitted September 18. While engaged in his work as lineman of telephone company a pair of pliers was let fall by a fellow workman who was at the top of a pole, and in falling struck squarely upon the head of the patient standing upon the ground. He was knocked down and for a short time rendered unconscious. A small ragged wound of the scalp was produced and was attended with only slight hemorrhage. He was at once visited by a physician who recognized the presence of a punctured fracture of the skull and had him sent to the Infirmary. There were present absolutely no cerebral symptoms, except the pain of the wound and severe headache. The nature of the injury demanded operation and September 19, under chloroform, a horse shoe shaped incision was made so as to have the wound occupy the center of the flap and the skull exposed. The skull was found fractured just to the left of the sagittal suture, well back of the crown. A one and one-eighth trephine was applied over the punctured bone and a disc of that size removed. The internal table of the skull was comminuted and quite a number of loose fragments removed. One long spiculum, one-half by one-eighth of an inch in dimensions, buried in brain substance to the depth of an inch, was found and removed. The wound in the scalp was closed with drainage, silk worm gut sutures being used, and the usual dressings applied. Recovery was uninterrupted and uneventful. The case demonstrated the importance of interference in fractures of the punctured variety. The patient was dismissed September 28.

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Case No. IX. *Internal Hemorrhoids.—Allingham's Operation.*—Mrs. W. H. H., æt. 32, Davidson County, Tenn. Admitted September 22, suffering with long standing internal piles and with chronic granular endometritis. Hemorrhages from the hemorrhoids were occasionally profuse and the patient was considerably exsanguinated from the loss of blood from that source and from menorrhagia. After preliminary preparation, the patient was anæsthetized with chloroform September 23; the anus dilated thoroughly and three large piles ligated, after dissecting them from the underlying parts. The uterus was then thoroughly curetted with both sharp and dull curettes and a considerably quantity of detritus removed. The patient improved rapidly and was discharged October 21, fully recovered.

Case No. XII. *Adeno-Fibroma of Breast.*—Miss A. W., æt. 49 years, Awalt, Tenn. Admitted October 10, with small adeno-fibroma of left breast. This patient had been operated upon the early part of the previous season for similar growth of opposite breast. The tumor was about the size of a hickory nut, hard and movable. Under chloroform anæsthesia October 11, an incision about two inches in length was made in a line radiating to the nipple, and the tumor exposed and enucleated with a little dissection. The wound was closed with continuous catgut suture. Healing took place rapidly and the patient was dismissed cured, October 18.

Case No. XVI. *Irregular Double Hare Lip.*—P. N. F., æt. eight and one-half months, resident of the city. Admitted October 14, with congenital hare-lip. This was a case of almost double hare-lip. The labial cleft on the left side extended into the nostril. A slight notch in the labia on the right side existed, but did not extend above the vermillion border of the lip. The intermaxillary bone was firmly united on the right side, but a notch was present, making a failure to unite on the left. The premaxillary bone was tilted on its axis, the free edge pushing forward. Under chloroform anæsthesia, October 14, the attachments of the lip were freely divided, and the case converted by incision into a double hare-lip. The edges of the notch between

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premaxilla and maxilla were pared freely, the attachment on the right side broken up with chisel, the bone forced into place and sutured with strong silk braid. The edges of the lip cleft were freely pared and closed with silkworm gut suture supplemented by superficial catgut sutures. Iodoform collodion was used as a dressing. The sutures were removed on the fourth day and union found perfect. The result was better than could have been expected. The intermaxillary bone maintained its place and assumed the correct position. The patient was dismissed October 20.

Case No. XVII. *Carious Terminal Phalanx of Great Toe; Excision.*—H. L., æt. 17, Shelbyville, Tenn. Admitted October 16, troubled with disease of the great toe resulting from removal of sub-ungual exostosis the previous season. The bone was evidently carious at the site of the former operation and there was some nail reformation which gave trouble. Under chloroform on the day of entrance the bone was freely exposed and the terminal phalanx entirely removed. The remnants of the nail were avulsed and an effort made to destroy the nail matrix. The wound did well and the patient was dismissed November 12.

Case No. XVIII. *Acute Suppurative Appendicitis.*—R. A. D., æt. 69, Allensville, Ky. Admitted October 16, with history of acute appendicitis of one week's standing. Palpation revealed a tumor in appendical region, rigidity of muscles, general swelling of abdomen, loss of area of hepatic dullness, etc. Pain and tenderness marked. Diagnosis, perforated appendix and general septic peritonitis. October 17, under A. C. E. anæsthesia abdomen was opened in the right linea semilunaris. A large quantity of fetid pus was evacuated, the abscess cavity found fairly well walled off, the appendix perforated and gangrenous was removed and the abscess cavity drained with rubber drainage tube and after packing with gauze was treated openly. The stump of the appendix was buried with purse string suture. The patient never rallied from the operation, but died October 18, from the continuation of the septic peritonitis which was present when admitted.

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Case No. XIX. *Inguinal Hernia and Hydrocele; Radical Operation.*—Houston B., æt. 11 years, Springfield, Tenn. Admitted October 17, 1906. Patient presented swelling of right side of scrotum of long standing. The enlargement was ovoid but irregular, elastic and painless and gave slight impulse on coughing. The mass was irreducible as demonstrated in attempts by local physicians to reduce it under chloroform. The light test showed translucency. Under chloroform, Oct. 18, the swelling was exposed by free incision and an encysted hydrocele of the cord about the size of a hen egg found to exist. This was incised, the fluid evacuated and the sac dissected. A small hernia high up was found and the hernial sac tied as high up as possible, and removed. The scrotal wound was closed by continuous catgut suture. This healed fairly well, though pus formed in the upper part, due to infection from the father's hands who persisted in handling the parts. The patient was dismissed cured October 27.

Case No. XX. *Chronic Granular Endometritis; Curettage.*—Mrs. L. J., æt. 50 years, resident of the city. Admitted October 18, with granular endometritis attended with excessive menorrhagia. The womb was in a state of marked hyperplastic enlargement, and the cavity somewhat increased in depth. As far as could be ascertained the appendages were in a healthy condition, October 19, under chloroform anæsthesia, the womb was dilated and thoroughly curetted, removing a large quantity of granular detritus. The patient progressed to a rapid convalesence and was dismissed cured, October 31.

Case No. XXIII. *Double Hydrocele; Operation by Volkman's Method.*—Jack D., æt. 59 years, Dot, Ky. Admitted October 18, with large double hydrocele of long standing. The enlargement was extreme and by reason of its size interfered materially with locomotion. The sides were symmetrically enlarged, elastic, pyriform in shape and showed translucency upon the light test. Under A. C. E., anæsthesia, both sides were operated on by free incision of four inches placed on the outer and posterior aspect of the scrotum, a large quantity of straw-colored fluid evacuated

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and the tunica vaginalis sutured with continuous catgut to the skin wound. Tubular drainage was placed in each sac and this was supplemented with a loose packing of gauze. Considerable inflammation of both testicles followed and on the left side scrotal cellulitis in severe form persisted for some time. The inflammation slowly subsided and the patient was dismissed November 19, completely recovered.

Case No. XXV. *Recurrent Appendicitis. Ecphyadectomy.*—J. E. D., æt. 19 male, Rutherford County, Tenn. Admitted October 20, suffering from a recent attack of appendicitis. The patient had had three distinct attacks before, at intervals of several months, the last of which had been very severe, there being present extreme pain, rigidity of muscles and marked tenderness over McBurney's point, with an ill defined mass in appendical region. Under treatment the inflammation gradually subsided, and on admission some tenderness was present and the appendix could be palpated. Under chloroform anæsthesia, the appendix was removed through incision made in right linea semilunaris and found enlarged and congested and contained two enteroliths. The stump of the appendix was invaginated with purse string sutures after securing the vessels of the mesappendix with catgut. The parietal wound was closed with silk-worm gut through and through sutures after closing the peritoneum with continuous catgut sutures. The patient made a rapid and uneventful recovery and returned home fourteen days after the operation.

Case No. XXVII. *Gall Stones; Cholecystotomy.*—H. B., male, æt. 49, Flat Rock, Tenn. Entered November 3, suffering with cholelithiasis. This patient gave a history extending over a number of years of chronic indigestion, pain and tenderness over liver, occasional severe paroxysms of colic, after which there was more or less jaundice which slowly disappeared, all of which indicated the presence of gall stones. Examination disclosed nothing positive, but a diagnosis of gall stones as being the origin of the bad health was made, and exploratory operation advised. Under chloroform anæsthesia, a four-inch incision was

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made over the gall bladder in the right semilunar line, the gall bladder exposed and calculi felt. The viscus was sutured to the peritoneum by continuous catgut sutures and incised to an extent such as to admit the finger. With scoop and forceps, 49 gall stones, ranging in size from a grain of wheat to a chestnut, were removed. The ducts were free of stones. A drainage tube was carried into the gall bladder, the upper and lower parts of the parietal wound closed by through and through silk-worm gut sutures and a loose packing of gauze placed in the wound. Recovery was rapid and complete and the patient was dismissed November 27, with the opening nearly closed.

Case No. XXX. *Necrosis of Femur—Sequestrotomy.*—J. P. P., æt, resident of the city. Admitted November 10. This patient had suffered for years from the effects of osteo-myelitis, resulting from a fall. Repeated abscess formation had followed at intervals in the region just above the knee, and at the time of admission there was present a number of fistulous orifices leading down to dead bone. At various times portions of the bone came away, the patient at one time removing a complete sequestrum of the femur nearly two inches in length and the entire thickness of the bone. The entire limb, thigh and leg were decidedly atrophied and the knee joint was anchylosed at an angle of thirty degrees, making him walk with difficulty and by the aid of a crutch. While amputation offered the best chances and was proposed, it was decided to attempt the removal of the dead bones. November 11, anæsthesia was begun with A. C. E., but owing to difficulty in producing narcosis, finished with chloroform. Incision of four inches made along the inner side of the thigh. Large cloacal opening present, small sequestrum found in lower part of cavity and removed. The cavity was thoroughly curetted and packed with gauze. The patient recovered rapidly and was dismissed December 2, with the parts nearly closed, but with some discharge, and still some carious bone.

Cases No. XXXII. *Persimmon Seed in the Right Bronchus—Tracheotomy.*—Pink C., male, æt. 12, Lafayette, Ky. Admitted November 12, for relief of trouble due to the presence of a per-

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simmon seed in the wind pipe. While running from school with the seed in his mouth he was suddenly seized with violent paroxysms of coughing and dyspnœa. The physical signs of foreign body were marked. Two days after the accident during which he suffered with dyspnoea and frequent paroxysms of coughing, he was brought to the Infirmary. Under chloroform November 13, the trachea was opened after the method of Bose. The insertion of a uterine tenaculum in the cricoid cartilage in the early part of the operation enabled the operator to lift the air passages forward, and to facilitate the exposure of the trachea. Three rings of the trachea were incised, the tracheal dilator inserted and the first violent expulsive paroxysm expelled the persimmon seed. A silver tracheal tube was inserted, but was removed in five hours. The wound healed rapidly and the patient was dismissed November 26.

Case No. XXXIII. *Retroversio Uteri; Hysteropexy*.—Mrs. C. W. W., æt. 34, Mayfield, Ky. Admitted November 21, for treatment of retroversion of the womb with its attendant menstrual difficulties. After the necessary preparatory treatment, November 25, under chloroform anæsthesia, the abdomen was opened by three inch incision in median line, the uterus found firmly bound down in its faulty position by adhesions which were broken up with difficulty, and the womb released. Two catgut sutures were used to fix the womb in extreme anteversion to abdominal parietes and the ventral wound closed with four through and through silk worm-gut sutures supplemented by interrupted superficial catgut sutures. The patient made a rapid recovery and was dismissed December 21.

Case No. XXXIV. *Urethral Stricture; Internal Urethotomy*.—H. C. T., æt. 42, Springfield, Tenn. Admitted November 22, with stricture of the urethra. The bulbous bougie detected several coarctations in the deeper parts of the urethra. A mild degree of cystitis was present and a persistant gleet troubled the patient. November 23, under local cocainization of the urethral canal, the several strictures were accurately located and divided thoroughly with Otis urethrotome. Large sized conical sounds

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were successively introduced and progressive dilatation kept up every other day until dismissal of the patient, December 1.

Case No. XXXVI. *Foreign Body in Left Bronchus; Tracheotomy.*—Lee H. æt. 15, Huntsville, Ala. Entered December 5, with the history of a foreign body in the left bronchus as was apparent on physical examination. The body was a metal whistle used in toy horns, which the patient had in his mouth, and which, in an unguarded moment was drawn into the windpipe. The usual symptoms followed and on entrance the patient had lost his voice and had occasional severe paroxysms of coughing. The body had been located at home by *x*-ray and was situated in the left bronchus, just below the bifurcation. Indications pointed to the fact that it was impacted. December 6, under chloroform, the trachea was opened and dilated and every effort made by inducing expulsive coughing, by forceps, by inversion of the body and succussion, to dislodge it without success. Efforts proving ineffectual, a silver tracheal canula was inserted and the wound dressed. Subsequently on several occasions under chloroform, attempts were made to remove the whistle, in one of which attempts the forceps caught the string by which the metal tongue of whistle was held and it was drawn to the neck wound, but the string came away in the forceps and the effort proved fruitless. However, all symptoms physical and objective disappeared and from the relief that followed (and this has been permanent) it is surmised that in the last effort at extraction the body passed into the pharynx, was swallowed and afterwards passed from the bowels. The patient was carefully watched and repeatedly examined and no evidence of the presence of the body again detected. The patient was dismissed March 25, 1907, apparently entirely relieved, and reports confirm the opinion that relief was obtained as surmised above.

Case No. XXXVII. *Uterine Fibroid: Abdominal Hysterectomy.*—Mrs. D. L. D., æt. 52, Springfield, Tenn. Entered December 10, for treatment of conditions brought about by small fibroid of the womb. Repeated hemorrhages had reduced the patient very much, so that when she was admitted she was ap-

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parently exsanguinated. December 12, under chloroform, the abdominal cavity was opened by median incision about four inches in length and the womb removed after the method of Howard C. Kelly. The operation was rapidly done, there being nothing of interest to note in securing the vessels on the two sides. The stump of the womb was carefully made extra-peritoneal by suturing the peritoneum over it from one pelvic wall to the other, and the parietal wound closed with through and through silk-worm gut sutures. The patient made an uninterrupted recovery and went home January 21.

Case No. XXXIX. *Appendical Abscess: Incision.*—Mrs. J. W. A., æt. 37 years, Tuscumbia, Ala. Admitted December 10, 1906. This patient had been sick for two weeks with appendicitis, elevated temperature, rapid pulse, tumor formation in appendical region, rigidity of muscles, continuous pain and tenderness and obstinate nausea and constipation. The symptoms had somewhat lessened in severity when she entered the Infirmary, but there was still great tenderness, rapid pulse, and while the bowels were more open, it was difficult to secure a movement. In the right side was a distinct swelling as large as a cocoanut, well circumscribed and dull on percussion. The area of hepatic dulness was absent. Under A. C. E., December 11, incision was made over the center of swelling and a large quantity of fetid pus evacuated. It was found that the abscess was completely walled off and while the appendix was found imbedded in the inner partition of the abscess cavity, it was deemed best not to disturb it for fear of general infection, and it was accordingly left in situ. Tubular drainage and light gauze packing was employed and the wound left open. Recovery was rapid, and the patient was dismissed January 2, with the wound closed and with cicatrization nearly complete.

Case No. XL. *Internal Hemorrhoids: Allingham's Operation.*—Sam U., æt. 40, Springfield, Tenn. Entered December 26, for treatment of internal hemorrhoids. Protrusion, hemorrhage and repeated inflammation had rendered operation necessary. Under chloroform, December 27, the rectum was freely dilated

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and four large hemorrhoids ligated in halves and removed. Patient rapidly recovered and left the Infirmary January 8.

Case No. XLIII. *Penetrating Wound of Neck: Fracture of Os Hyoides.*—W. C. T., æt. 28, resident of the city. Admitted December 28. While at work, the scaffold upon which he was working gave way and he fell a distance of fifteen feet, receiving in the fall a lacerated wound of the neck from the sharpened end of a piece of wood, the end penetrating the tissues to the extent of two and a half inches. Hemorrhage was profuse, but was checked by a temporary dressing and the patient removed to the Infirmary. Under chloroform, an irregular lacerated wound about two inches in length was seen in the superior carotid triangle. Hemorrhage was excessive and was found to proceed from wound of the superior thyroid artery. The vulnerating body had fractured the os hyoides, had punctured the thyro-hyoid muscle, opened the pharynx, the tendinous portion of the digastric muscle was torn, the submaxillary gland dissected bare in its lowest portion and all the parts of the superior carotid triangle and the lower portion of submaxillary triangle exposed as in a careful dissection. The wound was enlarged by incision about two inches, ligatures placed upon all bleeding vessels, the wound in thyro-hyoid muscle closed by continuous catgut suture, the tendinous ends of digastric muscle reunited and the fragments of the hyoid bone approximated by catgut sutures passed through the periosteum. The external portion of the wound was closed by interrupted catgut sutures and the inner portion left open after packing the cavity of the wound with gauze. The patient progressed satisfactorily, there being some trouble with deglutition and phonation for a time and was dismissed cured January 13.

Case No. XLV. *Uterine Hemorrhage from Retained Abortion; Curettage.*—Mrs. J. E. H., æt 26, Jamestown, Ind. Admitted December 29, suffering from the effects of incomplete abortion at three months, brought about by climbing a very long stairs to a lookout. The discharge was offensive and it was evidently the case that the greater portion of the conception had been retained. Under chloroform the womb was thoroughly dilated and its cavity cleaned out by curettage. The cavity was swabbed

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out with iodine and packed with gauze. The patient was dismissed January 4.

Case No. XLIX. *Granular Endometritis: Curettage.*—Miss P. T., æt. 29, Robertson County, Tenn. Admitted January 4, 1907, for treatment of endometritis with the usual menstrual complications and concurrent bad condition of health, metrorrhagia almost constant and profuse. Under chloroform anæsthesia, the cervical canal was freely dilated and the uterine cavity thoroughly curetted with sharp and dull curetes bringing away a considerable quantity of granulation tissue. The cavity was then swabbed out with strong tincture of iodine and packed with gauze. The patient did well and was dismissed February 7.

Case No. L. *Fistula in Ano.*—Lee W., æt. 32. Admitted January 3, with complete fistula in ano. Examination showed complete fistula and in addition a deep sinus extending for two inches alongside the bowel on the right side, but not communicating with the rectum. Under chloroform, the fistula was laid open into the rectum and the sinus freely incised to its upper extremity and both cavities packed with gauze. The fistulous track healed perfectly, but the sinus had not healed when the patient went home February 5.

Case No. LII. *Procidentia Uteri.; Trachellorrhaphy and Perineorrhaphy.*—Mrs. A. A., æt. 34, Florence, Ala. Admitted January 4, with procidentia of the uterus. The patient had sustained a laceration of the perineum some years previously, extending down to the sphincter and an extensive bilateral laceration of the cervix. The first laceration had been repaired immediately, but had failed to heal. The procidentia had resulted from loss of support and was rapidly becoming more pronounced. It was decided rather than resort to ventro-fixation, to repair the cervix and restore the perineum in the hope of curing the procidentia. Under chloroform, December 8, the clefts in the cervix were freely pared and sutured with strong chromatized catgut, three on the left side and four on the right. The ruptured perineum was restored by five silk-worm gut sutures supplemented by superficial catgut sutures. Healing was perfect, the peri-

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neal sutures having been removed on the tenth day. The procidentia while not entirely relieved was decidedly lessened and the patient's health greatly improved. She was dismissed February 5.

Case No. LIII. *Volkman's Operation for Hydrocele.*—E. B. C., æt. 33 years, resident of city. Admitted January 7, with moderately large hydrocele of right side. This condition was symptomatic, brought about by chronic epididymitis of long standing. Under chloroform the tunical cavity was laid open, a large quantity of fluid evacuated, quite a number of adhesions between the testis and the tunica vaginalis broken up and the tunica sutured by continuous catgut suture to edges of the scrotal wound. The opposite edges of the joined skin and tunica thus sutured were approximated by an interrupted suture and no drain or packing used. Rapid recovery ensued and the patient was dismissed January 18.

Case No. LIV. *Radical Operation for Left Inguinal Hernia.*—J. T. Mc., æt. 42, male, resident of the city. Admitted January 7. This patient had for a number of years been troubled with incomplete left inguinal hernia, which every variety of truss he had used had failed to retain, and its interference with his work as electrician rendered it necessary for him to obtain a cure. January 8, under first chloroform and then A. C. E., a modified Bassini operation was done, the deeper parts of the canal being sutured with strong catgut. Healing was typical and the cure perfect, and the patient was dismissed February 2. Since that time, now nearly six months, there has been no sign of return of the trouble, though the arduous nature of his daily work has been a great strain upon the parts.

Case No. LV. *Granular Endometritis: Curettage.*—Miss B. C., æt. 26, resident of the city. Admitted January 21, with a history of various menstrual disorders, the chief of which was excessive metrorrhagia. Fibroid was suspected, but not found. It was thought necessary to prevent further loss of blood to curette the womb, and accordingly under chloroform, January 22, the cervical canal was freely dilated and both sharp and dull

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curettes used with the result of bringing away quite a quantity of granulation detritus. Uterine cavity was swabbed out with strong tincture of iodine and packed with iodoform gauze. The patient was dismissed January 31. Subsequent reports have shown that the hemorrhages were stopped and the patient recovered.

(TO BE CONTINUED.)

MEDICO-LEGAL.

BY E. S. MC KEE, M.D., CINCINNATI.

DEFLORATION OF A SLEEPING GIRL.

That sexual intercourse with a sleeping person without her knowledge can take place is under general conditions very improbable, if not impossible. In the following case, reported by Hoffman, of Berlin (*Zeitschrift f. Medizinische Beampte*), a twenty-year-old girl, having drank deeply of spirits on an empty stomach, fell into a deep sleep. Her employer took advantage of her condition and succeeded in having sexual intercourse with her, her first experience, before she was aware of his intentions. Taking into consideration the condition of the girl, her employer was by the court condemned to the penitentiary.

CASTRATION AS A PREVENTIVE OF CRIMINAL ASSAULT.

The above is the interesting title of a valuable paper read before the Medical Society of Virginia, by Jesse Ewell, M.D., of Ruckersville, Va. The author said that as medical men we were called upon to treat the varied ills that flesh is heir to, and as conservators of the public weal, preventative measures naturally occupy much of our time and thought. He had recently seen the statement, which he had not doubt is true, that in the South the number of criminal assaults upon women have, within the past year, been more than doubled, compared to what they were before in the same length of time. The legal executions and lynchings have both failed in their one great object, namely, to

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prevent a repetition of the horrible act. Both law and lynching have fallen short of the mark, and the crime is on the increase. It is at their very doors. What can be done? We can at least study the situation. These assaults are committed principally by the vagrant class of the black race. The vagrant classes of both races do not read, and if a hundred of them were shot or hung for the unmentionable crime, but few of that class would ever hear of it; hence, shooting or hanging does not deter them. Castrate the criminal, cut off both of his ears close to his head and turn him loose to go where he will. He will harm no more women, and with this "mark of Cain" on his forehead he will deter more would-be criminals than would the shooting or hanging of five hundred.

THE MOST NOTABLE MEDICO-LEGAL ADVANCE.

In reply to the Hon. Clark Bell, President of the New York Medico-Legal Society, as to what had been the most notable advance in this department during the past year, it has been made in the now almost universally adopted methods of the embalmers of the country in using such fluids for embalming as do not contain poisons that would interfere with the detection of crime. More than twelve thousand undertakers in the United States and Canada now avoid the use of poisons in their embalming fluids that would interfere with the chemist in his analysis of any part of the cadaver when crime was suspected to have been committed by the use of those poisons commonly employed with criminal intent. Three States have passed laws forbidding this use of poisons in embalming. That embalming by the right brachial artery causes the fluid to enter the lungs of the cadaver embalmed has been proven beyond the question of a doubt. Thousands of embalmers throughout the country have been interested in this subject, brought up by the unfortunate Patrick case.

STERILIZATION OF THE CRIMINALS.

The King County Medical Society, of Washington, has had this subject up for consideration, and discussed it with vigor. They went on record as favoring such practice. This reform measure

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has advanced to such a stage in Wisconsin, where the legislative committee, which has investigated the asylums, will recommend the enactment of a law to sterilize the chronically insane and hopelessly feeble-minded, believing that this is the best method of protecting society against the increase of these unfortunates and degenerate persons.

NOT REQUIRED TO RESORT TO SURGERY TO CONSTRUCT WIFE.

The Court of Appeals of Kentucky says that in the case of Mutter *vs.* Mutter, the husband sought absolute divorce from the wife on the grounds of such malformation on the part of the wife as to prevent sexual intercourse. It was proven that the wife was over forty when married, and that the husband was her senior, a widower. That they lived together only three days, when he took her home and left her there, saying that she was not a natural woman and that he had been deceived and defrauded in marrying her. It was proven that the hymen was such as to not only prevent sexual intercourse, but also to interfere with menstruation. These facts were known to her before marriage, but she did not acquaint him with them. Physicians testified that through the aid of surgery she might be made capable of fulfilling the duties of a wife, but would not insure this. The husband declined to resort to these means and to live with his wife. The court ruled that the husband was not called upon to construct a wife by resorting to surgery, and granted him the decree.

EXPECTANCY OF LIFE.

Expectancy of life was brought up in the Supreme Court of Iowa recently. A husband, sueing a railroad company for the loss of the service of his wife by accident, introduced insurance expectancy of life tables. It was argued that the table was not competent evidence, because it did not purport to give the expectancy of life in the female. Counsel showed no reason for making a distinction between the sexes as to longevity, and in the absence of such evidence before the court it does not warrant the holding that there is any. Another ground of complaint was that the expectancy of life of the wife was alone considered; no consideration was taken of the expectancy of life on the part of the

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husband. This might be of great importance, for instance, in the case of an old husband and a young wife, for a man should not claim loss of services of a wife after he was dead.

A WOMAN'S NOSE AGAIN.

It was recently shown in these writings that the courts gave a larger verdict to a woman for an unsightly accident to her nose than to a man, reasoning that a woman's good looks were of much more value to her. Eva Frank, of Columbus, Ohio, through her father, Bennett Frank, has brought suit against the P. C. & St. L. R. R. for $50,000 for a broken nose. It must have been a big break.

AS TO WARNING THE PATIENT OF THE DANGER FROM CHLOROFORM.

The heirs of a Paris patient who had died while undergoing an operation sued the surgeon for $10,000 damages for neglect to warn the patient of the dangers from sudden death under chloroform. The local court awarded $1,600 damages, claiming that the operation was not vitally necessary, and that the patient was somewhat addicted to alcohol, which made the chloroform particularly dangerous to him, and he had not been warned of its dangers. The court of final appeal, however, reversed this decision. The *Semaine Medicale* for November 28, 1906, gives the full decision. The decision was, in brief, to the effect that alcohol is not a contraindication to the administration of chloroform; that chloroform is admissible and demanded in cases not dangerous to life; and the third plea concerning the necessity of the surgeon's warning the patient of the dangers of chloroform, these are too infrequent to demand this.

THE PATHOGENY OF CRIME.

This was the subject of an address by Dr. Arnold Lorand, of Carlsbad, before the Society of Medical Jurisprudence of Philadelphia at their April meeting. He considers crime a manifestation of disease, and will-power and facility of reasoning the two most important means for its prevention in the individual case.

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These forces become impaired in connection with disorders of the ductless glands. He dwelt on the mental symptoms attendant on the myxedema, and exophthalmic goiter, disorders dependent on diseases of the thyroid gland. He contended that criminal judges should be assisted by sworn experts in diseases of the nervous system, employed neither by the defense nor by the prosecuting attorney, but by the government. Religious fervor reaching to the heighth of superstition is one of the causes of crime. Christian Science is such a superstitution leading to manslaughter by negligence. A great curse is the idleness of the rich children of the rich. Criminals should be treated as if diseased mentally, and they should be placed at hard work, preferably in the open.

THE CRIMINAL INSANE.

A bill has been introduced into the Minnesota Legislature for the building of a State Asylum for the Dangerously Insane. Such an institution is much in need in Minnesota, as in many other States. Many older States have institutions of this character. Specially trained men are required as superintendents—medical men who have a certain familiarity with penal methods. A model institution should be used for the observation of suspected or indicted insane criminals or those who seek to excuse their crimes on the grounds of insanity as a defense. A few weeks' observation at an insane hospital would save the State or the relations of suspected cases a great deal of expense. When a criminal pleads insanity in a court, and is found to be sane, after a residence at such an institution, the trial court could complete its labors in short order, and thus avoid a long-drawn-out trial. The newspapers would have less nauseating news and the general effect would be wholesome and frequently preventative.

REGISTRATION OF FEMALES.

Connecticut, Colorado, Indiana, Maryland, New Jersey, New York, North Carolina and Virginia have laws for the registration of nurses, and Minnesota has one up before the Legislature. Most of the laws permit the registration of nurses over twenty-one years of age and of good moral character, holding a diploma

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from a training-school for nurses connected with a hospital or sanitarium giving a course of at least two years. The laws are generally liberal and broad, yet sufficient to prevent the registration of the graduates of correspondence schools, or those who have had no practical training at all. None of the laws prohibit or interfere with one's practicing nursing either for hire or for charity, or in her own family, provided she does not call herself a "registered" nurse.

NEW MEDICAL LEGISLATION IN THE NEW STATE OF WASHINGTON.

No session of the Legislature of this State would be properly conducted without some attempt to amend the Medical Practice Act. The thorn in the flesh at present is the Osteopath. From a "rubber" he has become inflated into believing himself capable of treating all kinds of medical and surgical ills, with great injustice to the educated physician and great danger to the public. The Osteopaths claim that a few are educated according to the Kirksville requirements, and, therefore, have a partial medical education, as understood by all physicians, while a much larger number are "quack Osteopaths." They think the latter should be muzzled. On the basis of this rather hazy mutual understanding, it is hoped to secure some form of medical legislation that will check this latter form of arrant charlatanry and humbuggery. It is expected that the present form of committment of the insane will be improved upon. The Governor advocates the increase of the salaries of superintendents from $2,500 to $4,000, thereby enabling the State to obtain the best specialists for the positions. Medical authorities seem to favor a standing commission of physicians in each county, selected with due regard to their fitness, to whose judgement shall be referred all persons charged with insanity. It is hoped to pass a law providing for a criminal insane ward in the penitentiary, and thus in a measure prevent the miscarriage of justice which has so often incensed the public mind.

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Selected Articles

Some Remarks on Nephrolithiasis.

BY RICHARD FROTHINGHAM O'NEIL, M.D., BOSTON.

Without question stone is one of the most important surgical diseases of the kindey. The subject is so vast and the literature so voluminous that it is obviously impossible to more than mention many of the important features of the condition and to speak but briefly of some of the others. Of the etiology and physical properties of calculi I shall say little, since the discussion would carry us deeply into the problems of chemistry and metabolic changes, but I will endeavor to spend most of our time upon the symptoms and diagnosis of the condition.

There is a very short distance between the formation of gravel and the formation of stone in the kidney. When the soluble substances in the urine become precipitated and are washed out by the urinary stream, we have the condition of gravel. When, by means of mucus or some other organic material this precipitate becomes agglutinated, we have a small calculus, or at least, the nucleus for one, which grows as fresh crystalline deposits are made upon it. This calculus either passes down the ureter with more or less colic to become a bladder stone or be passed per urethra. Otherwise, it remains in the kidneys, pelvis, calyces or substance, to grow and give rise to a variety of symptoms of a greater or less severity, but always sooner or later leading to destructive changes in the kidney tissue.

Morris divides calculi into primary and secondary: The former are met with when there is no infection present. Those formed from an acid urine being one or more of the following: uric acid, urates, calcic oxalate, cystine, xanthin and, rarely, indigo, those formed in an alkaline urine being of calcium carbonate and acid or basic phosphate of calcium.

Secondary calculi occur when there is change of reaction due

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to bacterial infection as in ammoniacal fermentation. They consist of the phosphates of ammonia and of magnesia.

In many cases a primary calculus becomes the nucleus for a secondary deposit because of the septic infection resulting from the irritation of the primary calculus. In point of size and number, calculi vary within a wide range, from very small stones which can readily pass through the ureter to those of enormous size, and in number from one to one or two hundred. In the calyces they may be slightly movable, in the pelvis they are, if of moderate size, much more freely so, and may fall into the ureter, blocking it. In either case they may take the shape of these cavities, sometimes filling them entirely and becoming firmly adherent which was the condition found in the present specimen. Those in the kidney substance are very prone to give rise to abscess formation with perinephritic rupture. According to Legueu and Albaran, bilateral stone occurred in nearly 50 per cent of the cases. Calculi may be met with at any age, but most commonly between twenty and forty. According to Morris the male sex is most often affected. Heredity seems to play a distinct part, particularly in the case of uric acid stones.

Briefly, the pathology of renal calculus may be divided into the aseptic and the septic changes due to their presence, which is the classification of the best authorities.

The Aseptic Changes.—There is, first of all, an irritation due to the passage through the kidney of a large amount of uric acid or calcic oxalate, etc.—in the precalculus stage; this irritation often becomes a catarrhal pyelonephritis which is soon followed by interstitial changes as well. The further change in the kidney may be brought about in two ways. There may be an atrophy of the kidney due to this calculus nephritis, or there may be destruction of the secretory tissue as a result of pressure from hydronephrosis, this latter occurring when the stone is of long duration and of sufficient size to entirely or partially occlude the ureter. There may also be an hypertrophy and induration of the perirenal fat, in some cases the kidney being replaced by fat tissue.

These aseptic lesions just mentioned, the nephritis, the retention of urine in the pelvis and the trauma of the stone, readily pave

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the way for septic infection which takes place through the blood or lymph stream or ascends the ureter from below. The colon bacilli is often the offending organism, the resulting lesion being pyelonephritis, pyonephrosis, nephritic and perinephritic abscess which may result through rupture in loin, groin, intestinal or thoracic fistulæ. Perinephritis often results in firm adhesions between the kidney and surrounding tissue, making operation difficult. When pyonephrosisis is present the kidney is generally of good size and may consist of a number of different cavities, more or less shut off from one another, containing pus, purulent urine and calculi. When there is more or less destruction of the kidney on one side the process is a slow one and the other kidney generally becomes hypertrophied; it may, however, become the seat of a nephritis and the subsequent changes with resulting stone, like its fellow. Another remote result may be the sudden blocking of the ureter by stone; this may occur in both kidneys simultaneously or, as is most usual, in each successively. This is a grave condition and if not relieved will lead to ulceration and perforation of the ureter with the resulting infiltration and abscess and sinus formation, or death from calculus anuria.

The typical picture of renal colic, as formally described, with its pain, passage of stone, etc., is well known to all and needs no comment. It is also well known, however, that the typical picture is often absent and that renal stones present a great variety of symptoms, simulating other conditions.

Before going into the method of diagnosis, it might be well to consider the various clinical courses taken by renal stone.

1. They may present the typical renal and ureteral colic and be easily diagnosed, but in some cases renal colic closely simulates appendicitis, gallstones and other acute intra-abdominal conditions, and must be differentiated from them.

2. They may remain innocuous and unsuspected for years, giving no symptoms or slight ones which have been misinterpreted or long forgotten. The case I shall speak of is a marked example of this. These cases are, of course, always liable to sudden activity; although in a number of cases, stones have been found postmortem that were unsuspected during life.

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3. In some cases the symptoms may be referred entirely to other organs, as the bladder, the testicle, the uterus and ovary—nothing being felt in the kidney itself. Frequent and painful micturition has often led to the diagnosis of cystitis and local treatment of the bladder with, of course, no relief. This is also true of other kidney lesions, as tuberculosis and neoplasm, both of which may, however, be complicated by stone. One should always have in mind the kidney as a causative factor of frequent micturition. Symptoms may also be erroneously ascribed to malposition of the uterus and diseases of the ovary. The cystoscope and *x*-ray have done much to clear up such cases.

The majority of cases, however, exhibit at some time certain typical symptoms, and careful attention to the history and painstaking examination of the patient will lead to a correct diagnosis. Among them are more or less frequent attacks of colic, due to the transient impinging of the stone in the pelvic end of the ureter with the pain in the loin or radiating to the testicle. Pain either in the kidney or referred to some other place is a frequent accompaniment of stone. It may be of all degrees of severity from an ache or feeling of lameness to pain of severe cutting or lancinating type. The referred or reflex pains have in part been mentioned and are described as the reno-renal reflex, pain in the other kidney, the reno-vesical, reno-testicular, etc. The pain is sometimes referred to the upper part of the thighs, the inside of the leg and the sole of the foot. The pain being largely mechanical and due to the actual bruising of the kidney by the stone is generally brought on or made worse by exercise or exertion and is relieved by rest.

Bleeding in stone generally takes place at some time or other in all cases. It is variable in quantity and as in the case of pain is generally increased by exercise and diminished by rest. This helps distinguish it from the bleeding of neoplasm. It is very apt to be associated with an attack of pain, the urine being dark or smoky for a few days following. The hemorrhage is rarely profuse, often microscopic. The bleeding of stone should be differentiated from the numerous other causes of hematuria.

Pus is present in the urine in many cases of calculus. Like the

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blood, it is due to the irritation of the stone; like it, also, it varies in amount according to the amount of inflammatory or destructive change there may be in the kidney. This may be all the way from a few microscopic leutocytes to the large amounts seen in pyonephrosis. A small or moderate amount of pus is rarely noted by the patient as the urine does not become offensive until pyonephrosis with decomposition is present, when the urine becomes very foul. He generally seeks advice because of the pain, colic or bleeding.

The diagnosis of renal stone not so many years ago was a matter of considerable difficulty and uncertainty—most of the operations being for the drainage or removal of badly diseased kidneys. At present we are much better equipped and the diagnosis should be made early in most all cases.

The methods to be employed are as follows:

First, a careful family and personal history, particularly as regards pain or disturbances of micturition.

Second, palpation of the abdomen. There is often tenderness and muscular spasm over the affected kidney. Tumor is present in hydro- or pyo-nephrosis of any extent. Palpation will also help to eliminate any other intra-abdominal process.

Third, careful routine chemical examination of the urine and examination of the centrifugal sediment for epithelial cells, casts, blood, crystals, tubercle bacilli and the ova of parasites.

Fourth, cystoscopic examination. This is a most important proceeding in the diagnosis, particularly when there is doubt as to which side is affected; and in those cases before referred to with marked bladder symptoms, cystitis, bladder stone, or tumor may thus be eliminated. If the case is bleeding sufficiently at the time, the diseased side may be determined, also the presence of another active kidney. Much valuable information may be obtained from observation of the ureteric orifices, the presence of edema or inflammatory changes about one or the other of them or alteration in their size or shape denoting an existing or pre-existing inflammatory condition of the kidney. Pus in small amounts coming from the ureter is difficult to be sure of and the ureter catheter had better be employed. When present in any

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amount, however, as in pyonephrosis, it is readily recognized. Ureter catheterization, or segregation, the former much the more accurate, should be employed to ascertain the condition of the other kidney and obtain the separate urine for examination. A slightly bleeding kidney may thus be recognized. The ureters may also be explored for patency. With the wax tip bougie and the phonophore I have had no experience; good results, however, are reported in the use of both by those familiar with them.

Fifth, radiography. In spite of the fact that many unfortunate and embarrassing mistakes have been made in the past in the interpretation of plates, such as pleboliths, glands, night shirt buttons, etc., the technique is constantly improving and a good *x*-ray by an experienced operator is of the greatest help to the surgeon. A good plate should show the transverse processes of the vertebræ and the structure of the last two ribs; such a plate will show clearly ureteral and renal stones, and, according to expert radiographers, is also of negative value. The plates should show both kidneys and the entire course of both ureters. According to Leonard nearly 50 per cent of all calculi occur in the ureters. Bevan has mentioned two cases where the symptoms, *i.e.*, pain and tenderness, were on one side, the x-ray showing the stone in the opposite ureter where it was found and removed. The case I shall mention is of interest in this connection. He also points out that in cases where the *x*-ray is negative it may be impossible to differentiate clinically tuberculosis, hypernephroma, tumor, etc., from stone. A doubtful shadow in the ureter may be verified by passing a ureter catheter with a wire stylet, then having another *x*-ray and noting the relation of the wire to the shadow as has been done by Brown, Lewis and others.

Sixth. Cryoscopy. Ascertaining the freezing point of the blood is of importance in determining the amount of renal efficiency—a lowered freezing point showing a lowered efficiency. The normal is 56 degrees C.

By the employment of some or of all of these methods a differential diagnosis from the various other conditions within and without the kidney can generally be made. These conditions have been briefly alluded to already and time will not allow me to

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take up the differential diagnosis any more in detail. They include tuberculosis, cancer, cystic kidney, tumor, abscess, floating kidney, etc. However, at times the *x*-ray will be negative or unsatisfactory, ureteral catherization cannot be employed and the patient will present an array of symptoms that cannot be definitely interpreted. In such cases the condition can be diagnosed by exploratory operation only.

The treatment of stone may be divided into the expectant and the surgical. The former, according to Bevan, should be limited to the following conditions: (1) When the attacks are infrequent and mild and by *x*-ray the stones are of a size to be readily passed; but such cases should be kept under close observation; (2) where age or disease in other organs renders the removal of a stone more dangerous than its presence, and (3) where a stone is arrested in the lower end of the ureter when there is hope of assisting its passage by injection of oil or liquid vaseline into the ureter.

Without question surgical removal should be the treatment of most all cases of stone. When the diagnosis has been made early, operation should be most strongly urged as it is at this time that the most brilliant results are obtained with the greatest safety.

Nephrolithotomy is one of the most satisfactory of surgical operations when performed before the kidney substance has been injured or destroyed. When suppurative changes have taken place the indications for surgical interference are none the less imperative, and the course to be followed by the surgeon must be determined by the existing conditions in each case. Time will not permit a discussion of these conditions; suffice it to say that one of the following procedures is open to him: (1) He may cut down upon the kidney to explore it or evacuate any neighboring collection of pus. (2) He may drain the kidney either by opening the pelvis or by splitting the cortex. (3) He may remove the kidney at once or leave it for a subsequent operation.

In bad cases the latter is generally the operation of choice, being done when the patient is relieved of his sepsis, and is often necessary for the cure of chronic fistulæ. The treatment of cal-

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culus anuria is immediate single or double nephrotomy, as the case may be.

It is wise if possible to explore the ureter at the time of operation by passing a bougie down through it.

The mortality of nephrolithotomy in uninfected kidneys is about 3 per cent. When septic processes have intervened it is said to be ten per cent—a strong argument for early diagnosis and treatment.

In closing I shall refer briefly to a case which illustrates some of the points heretofore mentioned.

The case occurred on the service of Dr. C. L. Scudder, at the Massachusetts General Hospital, who operated and who has kindly allowed me to present it. I had the opportunity to see the patient several times in the Out-Patient Department and with Dr. Davis, who made the cystoscopic examinations:

He is forty-one years old and gives the following history: No venereal diseases. He had suffered from attacks of pain in the left loin going down into the left testicle. The first attack occurred when he was sixteen and was constant and severe. He passed a very little blood at times and some gravel after the pain; once a stone the size of a pea. Four years ago he had a severe attack and thinks the stone passed into the bladder at that time. For the last three years he has had bladder pain and symptoms of vesical calculus. All of his previous symptoms were referred to the left side. Multiple vesical stones were readily detected with the searcher and he was recommended for operation for vesical calculi, with question of renal as well. He was cystoscoped later and two good-sized stones seen. An *x*-ray showed these very well and also a large shadow in the right kidney; nothing in left. His condition was not of the best, so it was decided to remove the bladder stones first and study the condition of the kidneys. The ureter could not be seen with any degree of accuracy at the first cystoscopic examination. A suprapubic cystotomy was done on February 18. He improved very much after this and a second cystoscopic examination was made. This showed apparently nothing, but pus coming from the right kidney and a normal efflux from the left. The left side was catheterized later and

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some pus was found coming from it as well. On March 7 the right kidney was explored and a large branched calculus was found and extracted with considerable difficulty, as it was intensely adherent. The patient did well. Some urine escaped for a time through the loin, showing that there was active renal tissue left, although at the operation the kidney did not look promising. The patient's condition would not have warranted a nephrectomy at the time.

The interesting points in this case are: (1) That a stone of this size could remain in a kidney so long a time without giving any hint of its presence, or without destroying the kidney entirely. (2) The absolute diagnosis by the *x*-ray and the confirmatory evidence of the cystoscope, I think without doubt, that the bladder stone came from the left kidney which at present, as far as can be told, is the seat of a slight pyelitis only.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

Resection of Ten Feet of Small Intestine.

Dr. Stachlin reports a case of strangulation of a very large inguinal hernia on the right side in a man, aged 47. Kelotomy was performed on February 25, 1906, within a few hours after the sudden descent of the rupture. On exposure of the gut the coils brought immediately to view were found to be gangrenous, and the underlying coils were highly congested and gangrenous here and there throughout their entire extent. The whole of the corresponding portion of the mesentery had turned a deep mahogany color; the veins were thrombosed, and the arteries had ceased to pulsate. The entire length of the gut which contained gangrenous areas was securely clamped off and removed. The mesentery was ligatured and resected near its upper attachment, and the ends of the gut were brought together and reunited by end-to-end anastomosis. The patient was discharged cured at the end of the seventh week. The patient's convalescence was watched with apprehension that the stools might become permanently liquid and so cause gradual inanition. The author reports that this was not the case, and that the man eats and drinks as before and has regained his former weight. The entire length of the gut removed was, it is stated, ten feet two inches, and it was taken as nearly as could be made out from the middle of the small intestine.—*Annals of Surgery*, January, 1907.

Bony Ankylosis in Tuberculosis Arthritis.

Professor Howard Marsh (*Brit. Med. Jour.*) says: "I have several times found knee-joints the seat of tuberculosis but apart from supporation become so completely fixed within six months as strongly to suggest the conclusions that bony ankylosis had taken place. And the remarkable fact has been observed that

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nothing more has been seen of any active tuberculosis disease. The explanation I would suggest is that in some individuals a joint instead of falling an easy prey to tuberculosis invasion becomes, as the result of the irritation which the bacillus produces, the seat of a plastic inflammation similar to that which produces ordinary callus, and it is by this process that the joint surfaces are firmly united. In the meantime the bacillus inclosed in an area of diminished vascularity perishes and the tuberculous process is brought to an end. This speedy and, as it may be termed, natural cure of tuberculosis by plastic inflammation may very well be set against the inconvenience of the ankylosis by which it is attended. The fact that bony ankylosis may occur in tuberculous joints without suppuration should be kept well in mind in clinical practice, for otherwise the mistake may, in a moment of optimism, be made of promising recovery with free movement. Even in cases which are recognized early and adequately treated ankylosis may occur.—*International Jour. of Surg.*

Discharge from the Ear as a Probable Factor in the Spread of Diphtheria.

Dr. J. Biernacki and C. Montague Heanley call attention to the importance of the discharges from the ears as a factor in the spread of diphtheria, it being well known that school children often have ear discharge after diphtheria and that this may contain the specific bacilli. These were found by them in 16 to 19 cases of ear discharge, and in a majority of the positive cases hundreds of bacilli were observed in a single field. The stage in which this condition obtains was found to last sometimes several weeks, so that the output of the bacteria must have been enormous. The bacilli were found as late as ninety-one days from the onset and on the sixtieth day of the discharge, and in scrapings from the meatus a week after the discharge had ceased and syringing had been stopped as unnecessary. In one case the interval from the onset to the appearance of the discharge exceeded forty days; in three cases, thirty days; in six cases, twenty days; in seven cases, ten days; in two cases, less than ten days.—*Boston Med. and Surg. Jour.*

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A Case of Typhoid Perforation of the Appendix; Operation and Recovery.

Henry Moffat, of Yonkers, N. Y., details a case of typhoid, in which appendicitis occurred from a Peyer's patch, which, becoming ulcerated, perforated the appendix and necessitated operation. The patient recovered. The character of the mucous lining of the appendix was its solitary and agminated follicles, crypts of Lieberkuhn and lymph nodes makes it particularly liable to ulceration in typhoid fever. Post-typhoidal appendicitis also accurs, in which the appendicitis may arise from necrotic remains left in the appendix, or a small perforation which is rapidly walled off by protective adhesions, and ltaer ruptures and produces a large abscess. It is somewhat difficult to differentiate typhoid from appendicitis. Pain, tenderness and distention of the abdomen are common to both, but when muscular rigidity is added appendicitis may be suspected, with vomiting and sudden increase of fever. A careful blood count is of more value than the Widal reaction, which may not be present before the tenth day of the disease. The leucocyte count is always low in typhoid. Perforation will be indicated by sudden collapse with all of temperature. Operation is not necessary for typhoid appendicitis except when perforation occurs, and then it should be done quickly and thoroughly.—*Medical Record.*

MEDICAL

Treatment of Sciatica.

The following is taken from the *Monatschrift fuer Orthopaedische Chirurgie und physikalische Heil und Unter suchungsmethoden,* No. 4, April, 1907, *beilage zu Deutsche Medizinal Zeitung,* March 25, 1907, of Berlin, under the title "Behandlung der Ischias, von Dr. E. S. McKee, Cincinnati," and is abstracted for the original in *Blatter fuer klinische Hydrotherapie,* February, 1907, of Vienna.

First a calomel purge, then salts; in constitutional disease as soon as possible introduce treatment for the cause; caution with

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morphine; in rheumatic cases salicylate preparations, in syphilis iodides, in gout colchicum and saline mineral waters.

Hypodermic injection of sterilized air. First sterilize the immediate cutaneous region, then insert a sterilized Pavas needle into the skin and connect with a thin rubber tube, which is again connected with a glass tube containing a bit of sterilized cotton, and then one drives by means of a rubber balloon the air slowly under the skin. Naturally, care must be taken that the Pavas syringe needle be not run into a blood-vessel, which easily occurs. Gentle massage should follow this procedure till the air is all absorbed. The rest-cure of Weir-Mitchell is in some cases very successful, especially in those where their means of livelihood has been an active one. Massage along the nerve, though quite painful, often breaks up adhesions, which are the cause of the disease in many instances. It is a rule, however, that in true neuritis massage is not followed by good results. Massage, and especially mechanic vibrations, are of especial worth in chronic cases with beginning atrophy.

Hydrotherapy, systematically used, deserves due consideration. The wet pack over night diminishes the pain remarkably, as well as having a favorable influence on the neurotic process. The next morning the leg is unpacked, washed with warm water and massaged. Ten or twelve of these applications are usually sufficient. In subacute cases the half steam-bath is of service. Patient sits in a steam container which reaches only above the hips. This half steam-bath does not weaken the patient and allows of a higher temperature; 44 degrees C. can be endured for ten to fifteen minutes without discomfort. Afterwards the patient is put in a bath of 35 degree C. for eight minutes and the diseased hips douched with water at 40 to 44 degrees C. This procedure can also be combined with swimming baths. Very often the drinking of large quantities of water is advisable.

Electrotherapy.—Galvanic current direct on the nerves, four to eight minutes, highest three to five milliamperes. Also the interrupted galvanic current stimulates the muscles in a mild way, holds the tissues in a good condition and prevents atrophy. The static (Franklin) douche with positive pole on the painful part

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is followed by good results. The apparent anodyne action of faradism in sciatica is due to its alterant action on the muscular tissue, and through that on the circulation. The current dare not be increased to painfulness.

Surgical Treatment.—In long-standing cases one is often led to make an exploratory incision, lay the nerve bare and separate some adhesions. In bloody nerve-stretching we find good and bad experiences. This operation is directly contraindicated where neuritis is present, as in these cases myelitis not infrequently follows. There is also a so-called bloodless nerve-stretching wherein the patient is under ether, the thigh is forcibly flexed on the hip joint, with the leg extended at the knee, which position is maintained for some minutes.

The cure is easier when the patient is not too old and does not suffer from other diseases. The principal thing in the treatment consists in the careful observation of the patient, so that nothing is overlooked. The physician shall at once in the beginning commence with a systematic cure, and if it does not go forward seek for his failure, for failure lays somewhere certainly. Exact diagnosis of the condition of the patient is the first and last means of treatment.—*Lancet-Clinic,* May, 16, 1907.

When Shocked by Electricity.

In additional to artificial respiration the use of atropine, hypodermically, as a respiratory stimulant will suggest itself, with glonoin and strychnine as circulatory stimulants. The clipping follows:

"How many in this twentieth century are murdered through ignorance? I allude to people shocked by electricity. When a man is electrocuted he received a shock of over 2,000 volts. And under the best conditions I will assert that if the condemned should receive a pardon after receiving this charge of 2,000 volts in ten minutes' time he might be alive and enjoying the benefit of that pardon.

"Trolley wires which kill so many people carry only 500 volts—a force just sufficient to give a very interesting vaudeville exhibition, showing how a person is revived after being shocked.

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"Every fireman and policeman in the city ought to know what to do when a person is shocked by electricity. When a man is under the influence of ether he breathes naturally, but when 'under the influence' of electricity, he does not breathe at all. The first thing to do after a man has been shocked is to force him to breathe. Take off the coat, place it under the shoulders. Open the clothes around the throat and chest. Draw the arms over the head and out to full length. This expands the chest and permits the air to enter. Bring the arms back, doubled at elbows, and bring them forcibly against the chest, expelling the air. Keep this up for one hour if the person is not revived sooner, and breathes as fast as a person should breathe. While doing this send some one for a doctor.

"A young man at South Bend received a shock of 2,500 volts. He had hardly fallen to the floor before he was grabbed by an electrician who tried to revive him. In five minutes' time he was all right. About twenty-four hours later he felt pain from the shock. He suffered for about a week and then was as well as ever.

"A man who revives a person shocked by electricity is as much a hero as one who saves another from a burning building."—*Hot Springs Med. Jour.*

Pulmonary Tuberculosis and Peripheral Trauma.

Ewald discusses a case in which a healthy young man had his finger crushed in a factory and was in the hospital for six weeks. Soon after his dismissal he developed symptoms of pulmonary tuberculosis, to which he succumbed a year or so later. He claimed indemnity from the acident insurance company, affirming that his lung trouble was the direct result of the peripheral injury, and the courts sustained the plea. The company had, therefore, to pay him full indemnity and to pension his widow. Ewald comments that this decision might be applied with equal force to all cases of internal affections which develop after a peripheral injury requiring hospital treatment. The accident insurance companies would have to go out of business, he adds, if this view

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should be generally adopted. Physicians should be very guarded in making probability out of possibility in their estimate of such cases, as so many factors contribute to the final outcome.—*Munchener medizinische Wochenschrift.*

The Therapeutic Value of Digalen.

This recently introduced active principle of digitalis has been used considerably and with success. Dr. Z. F. Orlovski (*Russky Vratch,* Vol. 5, No. 34) has employed it in a series of cases and finds it to be a reliable remedy for regulating the activity of the heart. Digalen has some advantages over digitalis, namely, the possibility of more exact dosage and the complete absence of all collateral effects. It can also be used hypodermically; however, there is a rather sharp local reaction. Intramuscular injections of the drug, on the other hand, are well borne. The remedy has, like digitalis, a certain cumulative effect. In some cases where digitalis failed, digalen gave satisfactory results. The doses employed by the author varied from 20 to 30 drops three times daily.—*Critic and Guild,* February, 1907.

Subcutaneous Injections of Oxygen in the Treatmant of Sciatica.

Professor R. Maisalongo and Dr. G. Danio, in Verona (*Therapeutische Monatchuifte,* March, 1907), reports the result of treating twenty cases of sciatica with injections of oxygen. Some of the cases were of long standing and very severe; the result in all cases were excellent. After ten or twelve injections in the course of two or three weeks nine of the patients were completely cured and the others were cured in a short time afterwards. The oxygen was injected deep in the tissue at the most painful places, by means of a long needle connected by rubber tubing with an oxygen generator. They attribute the good results not alone to mechanical effects, and assert that the oxygen probably helps to bring about a normal metabolism.—*St. Louis Medical Review.*

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OBSTETRICAL

Chloroform for Rigid Perineum.

Chloroform may be used as suggested by Southworth in the following combinations to overcome a rigid perineum in labor; Chloroform, 60 00 or oz. ii; ætheris, 30 or oz. i; spiriti odorati, 500 or O i. M. S.—Apply locally. This mixture acts quickly and well, large heads safely passing the perineum, which had previously threatened an extensive rupture.

Ovarian Extract in the Obstinate Vomiting of Pregnancy.

G. Stella (*Semaine medicale*, 1906, xxvi, 523—Ref. *American Journal of Medical Sciences*, April, 1907) says that ovarian extract has been of great usefulness, in his hands, in treating the hyperemesis of pregnancy. His results have been exceedingly striking—the patients being immediately relieved of their troublesome symptoms—and he states that it should always be tried before the emptying of the uterus is considered. The dosage which is 3 drammes (45 grains) may be progressively increased *to twice this amount.—St. Louis Medical Review.*

A Case of Multilocular Glandular Cystoma Complicating Pregnancy.

B. S. Talmey, of New York, describes a case of multilocular glandular cystoma, the cyst being the size of a child's head, complicating pregnancy, in which the tumor had been raised out of the pelvis with the growth of the uterus and had in no way interfered with the delivery of a child in the normal way. The patient came under the care of the physician five weeks after labor, having had two severe attacks of pelvic pain, corresponding with twisting of the long pedicle of the tumor, and with a beginning pelvic peritonitis due to gangrene. This case serves to show that it is not always necessary to operate on any case having a pelvic tumor during pregnancy.—*Medical Journal.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

MEDICAL DEPARTMENT OF VANDERBILT UNIVERSITY.

We take pleasure in calling the attention of the profession to the advertisement on the outside cover page of the Journal of the Medical Department of Vanderbilt, and to important changes in the able teaching corps of that institution. The future of this prosperous department of a great university is certainly great and the improvements and additions contemplated, will add greatly to its usefulness as one of the leading medical schools of the South. This department has recently resigned its membership in the Southern Medical College Association and been admitted a member of the American Association of Medical Colleges, a very important step and one that is fraught with much significance as regards its standing among the medical institutions of the country. It means that this college is not compelled to recognize students who come for advanced standing from colleges not members of the Association without qualifications demanded by the rules of the Association. A bright future is before this department in the clinical field of teaching. The Methodist Church of the South has in contemplation the establishment of a magnificent hospital for which a very desirable site has already been purchased, the building and equipment to cast $200,000, and the full control of this hospital will be vested in the medical department of Vanderbilt University. The advantages of this movement is readily apparent and will add immeasurably to the teaching facilities of the school. For the present, however, wards will be extemporized by converting the first floor of the college building into a charity hospital with four spacious wards for the two sexes of each race, where bedside

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lectures can be gratuitously given to its students. Lectures and recitations will be given in the forenoon, while the afternoons will be entirely devoted to laboratory work and bedside clinics. This will leave the evenings free for the students to devote to reading. A library has also been opened up in the college building for the use of students, an innovation of the greatest possible importance. Another step in the right direction is the increased tuition fee of $25, making the fee in every case strictly $125, instead of $100, as before. These changes and improvements denote the proper spirit in the controlling authorities of the school, and we feel sure in view of the earnest work that has been done and the progressive spirit herewith shown that the Medical Department of Vanderbilt will rank in the future as it has in the past as the leading medical school of the South. We wish it continued success and abounding prosperity.

The *Interstate Medical Journal* (St. Louis) announces the purchase of the *St. Louis Courier of Medicine,* one of the oldest medical journals in the West, and its consolidation with the *Interstate* on July 1.

The *St. Louis Courier of Medicine* was established in 1879 by an association of prominent St. Louis physicians. It has always commanded a large following throughout the West and South, and held the respect and esteem of the entire profession of this country.

This merger removes from the field an old and highly esteemed contemporary, and its consolidation with the *Interstate* adds strength and prestige to that periodical. This is the fourth medical journal that has been purchased and absorbed by the *Interstate* during the past few years.

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Reviews and Book Notices

Modern Medicine; Its Theory and Practice.—In original contributions by American and foreign authors. Edited by William Osler, M.D., Regius Professor of Medicine in Oxford University, England; formerly Professor of Medicine in Johns Hopkins University, Baltimore; in the University of Pennsylvania, Philadelphia, and in McGill University, Montreal. Assisted by Thomas McCrea, M.D., Associate Professor of Medicine and Clinical Therapeutics in Johns Hopkins University, Baltimore. In seven octavo volumes of about 1,000 pages each; illustrated. Volume II, just ready. Price per volume, $6, net; leather, $7 net; half morocco, $7.50 net. Lea Brothers & Co., Publishers, Philadelphia and New York. 1907.

The early appearance of Volume II. of this stupendous and classical work is an enthusiastic earnest of the rapid progress that is being made in the publication of the system. This volume more than ever indicates the great value of the forthcoming system and stamps it as the most monumental publication as yet undertaken. It will prove a boon to progressive physicians.

Reverting to the contents of the volume in hand, Hektoen opens with an introduction on the study of Infections, following which McCrea considers Typhoid, Typhus, and Relapsing Fever; Councilman, Smallpox and Chickenpox; Dock, Vaccination; McCollum, Scarlet Fever and Diphtheria; Ruhrah, Measles; Rubella, the Fourth Disease, Erythema Infectiosum, Whooping Cough and Mumps; Lord, Influenza; Coleman, Dengue; Koplik, Meningitis; Anders, Erysipelas; Musser and Norris, Pneumonia; Pearce, Toxæmia and Pyæmia; Poynton, Rheumatism; Dunbar, Cholera; Carroll, Yellow Fever; Calvert, Plague, and Shiga, Bacillary Dysentery.

Dr. Osler's position is such that the leaders of the profession of two continents have stood ready to respond to his request to participate in the creation of this great work. His assignment of subjects shows his keen judgment of the men qualified to write with the highest authority. The resultant product will cover the whole field of medicine in its present advanced state of cultivation. It records the new level of knowledge which is open

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in its pages to every physician who desires the best information on any point of theory or practice.

The Practice of Obstetrics.—By American authors. Edited by Charles Jewett, M.D., Professor of Obstetrics in the Long Island College, Brooklyn, N. Y. In one handsome octavo volume of 786 pages, with 445 engravings in black and colors and 36 full-page colored plates. Cloth, $5 net; leather, $6 net; half morocco, $6.50 net. Lea Brothers & Co., New York and Philadelphia.

The appearance of this excellent treatise in its third edition testifies to the fullest extent to the high place it has reached in the estimation of the professional public. It is a matter of note that it is only in rare instances that works of composite authorship demands new editions, and yet this work appears in its third edition. The work has been systematically revised in all its parts and considerably enlarged. As a text-book it has taken high rank and will still further gain in the estimation of obstetricians and students of medicine. We feel sure that no recent publication on the subject will prove more acceptable to the profession, and we unhesitatingly recommend the work as a most useful one.

Diseases of the Rectum.—Their Consequences and Non-Surgical Treatment. W. C. Brinkerhoff, M.D., author. Steinway Hall, Chicago, Ill. Price, $2. Published by Orban Publishing Co., 17-21 E. Van Buren St., Chicago. 1907.

We have glanced over this monograph and find that it is an enthusiastic exponent of the injection treatment of hemorrhoids in violent opposition to treatment of that condition by surgical operation. While it contains a great deal that will prove of interest to the professional reader, we do not think that the author's efforts to subvert the principles that underlie surgical operations for hemorrhordal disease will succeed.

Diseases of Infancy and Childhood.—Their Dietic, Hygienic and Medical Treatment.—A text-book designed for Practitioners and Students in Medicine. By Louis Fischer, M.D., Visiting Physician to the Willard Parker and Riverside Hospitals, of New York City; former Instructor in Diseases of Children at the New York Post-Graduate Medical

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School and Hospital, etc.; Fellow of the New York Academy of Medicine. With 303 Text Illustrations, several in colors, and twenty-seven full-page half-tone and color plates. 979 royal octavo pages. Extra cloth, $6.50 net; half-morocco, $7 net. Sold only by subscription. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This encyclopedic volume accentuates the rapid strides made in this department of medicine during the last decade. The demands of the times make the publication of such works as this a necessity. In reference to this excellent work we can truthfully say that it fully meets all demands for a complete and exhaustive treatise on pediatrics. The physician is sure to find in it a most invaluable work of reference and an exposition of the subject that is exhaustive and up to date. The book has been divided into twelve parts:

I. The New Born Infant. II. Abnormalities and Diseases of the Newly-born. III. Feeding in Health and Disease. IV. Disorders Associated with Improper Nutrition and Diseases of the Mouth, Oesophagus, Stomach, Intestines and Rectum. V. Diseases of the Heart, Liver, Spleen, Pancreas, Peritoneum and Genito-Urinary Tract. VI. Diseases of the Respiratory System. VII. The Infectious Diseases. VIII. Diseases of the Blood, Lymph Glands or Nodes and Ductless Glands. IX. Diseases of the Nervous System. X. Diseases of the Ear, Eye, Skin and Abnormal Growths. XI. Diseases of the Spine and Joints. XII. Miscellaneous.

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Publisher's Department

The Treatment of Inoperable Malignant Tumors—Carcinoma.

I have two reasons for presenting a discussion of the treatment of cancer at this time: First, the importance of the subject, and, second, the hope that I have discovered a method which may result in saving many lives. It has been affirmed by Wutzdorff that there has been an increase in the number of casese of cancer in the last few years, and some, with Sir W. M. Banks, believe the increase is due to excessive meat eating. At any rate, it has been shown that many cases occur in robust and well-fed individuals and especially in the comparatively young of both sexes. It often happens that the presence of such a growth is not suspected until it is too late for operative interference, because of the fact that the appearance of the patient does not indicate the progress of the disease (Nothnagel). Many cases also occur which cannot be operated on because of the location, as when situated near vital organs or around important blood vessels. Then, again, there are patients who will not submit to an operation.

To the medical man has usually fallen the duty of caring for these classes of unfortunate cancer patients and from time immemorial the professional mind has been taxed to discover some means of relief, some agent or remedy which might destroy the abnormal growth.

Lauder Brunton was the first to investigate the chemical composition of cell-nuclei from which has been secured a compound called nuclein. This substance is an albuminoid and contains phosphorus. Nuclein is the most distinctive element of leucocytes, being the constituent by virtue of which the cell grows (E. R. Larned). Vaughn and McClintock have demonstrated that the nuclein is the germicidal agent in blood plasma and is furnished by the polynuclear leucocytes.

The bromide of gold and arsenic is another remedy which, in

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my hands, has seemed to prove useful in the treatment of inoperable carcinoma; but I have always used it in connection with other agents. I have had more confidence in the nuclein than in the bromide, chiefly, perhaps, because I have had two cures in which I did not use the bromide, while I have had none where nuclein was not used. I have come to consider the administration of nuclein and the bromide of gold and arsenic together as a most rational and valuable treatment in cases of inoperable carcinoma. It is the combination upon which I depend rather than on either agent singly.

I have used this method of treatment in many cases with apparent benefit, but I am able to report only five cases in which the treatment was carried out as prescribed from the time the patient came under my observation until the termination of the case. One of the cases died. The other four recovered.

Treatment.—The local treatment consisted of the use, by mouth, *of a 2 per cent solution of Hydrozone.* The patient was told to drink half a pint of this solution half an hour before meal-time, lie on the back for five minutes, then turn on the right side and remain in that position for 25 minutes. This remedy was given for its antiseptic effect. The internal treatment was nuclein. The particular preparation was Reed and Carnick's protonuclein. The dose was 24 grains a day. This time the patient was kept under observation for a month, until the symptoms were not quite so severe. The treatment was continued, however, and after several weeks I called to see the patient in another exacerbation of her symptoms; but this time they were not so severe. After a few days I dismissed her again, with advice to continue the nuclein, *but to omit the Hydrozone.* Some five months later I called to see the patient and found her at work about the house. The symptoms and tumor had disappeared and the cachectic look had given place to a more healthful appearance. I did not see her again, but three years later I was informed that she was well and had had no return of the old symptoms.

In presenting the foregoing case, the author does not suggest that he has found an infallible cure for cancer, but rather that such results must convince us that cancer may be placed on the

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list of curable diseases. The treatment, to be successful, requires great care in carrying out the method. If the remedies are carelessly administered, satisfactory results cannot be expected. In all serious cases and internal tumors, I advise remaining in bed for weeks, depending upon conditions in individual instances. The bromide [i. e., the Arsenauro] must be gradually increased. Few patients will bear large doses from the beginning.—J. M. G. Carter, M.D., Sc. D., Ph. D., Waukegan, Emeritus Professor of Clinical Medicine, University of Illinois; Fellow of the American Academy of Medicine; Ex-President of the Illinois State Medical Society, etc., etc. (Abstract of paper read before the Section on Medicine of the Illinois State Medical Society, at Springfield, May 15-17, 1906. *Illinois Medical Journal, January,* 1907. The bibliography is omitted.) Published in *The Illinois Medical Journal,* also in *The Therapeutic Medicine,* for April, 1907.

A Blend of Harmonizing Drugs.

The above condition has been fulfilled in Sanmetto—its ingredients harmonize, forming a most perfect blend of the santal and saw palmetto with soothing demulcents and well chosen aromatics, resulting in a soothing, healing and restorative remedy for the disease genito-urinary, economy, at once efficient, and adapted alone or in combination with other drugs.

Codeine Safety Again Demonstrated.

Dr. E. S. McKee, of Cincinnati, Ohio, speaking of Codeine, in the *Denver Medical Times,* says: "This drug, according to Butler, is one-fourth as toxic and effective as morphine. It is less depressing and more stimulant, does not constipate, cause headache or nausea, and rarely leads to the formation of a habit. Codeine seems to exert a special, selective, sedative power over the pneumogastric nerve, hence its value in irritative laryngeal, pharyngeal and phthisical coughs with scanty secretion. Like morphine, it has proved of value in checking the progress of

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saccharine diabetes, and it has been used for long periods without the formation of the drug habit, inasmuch as when glycosuria was brought to a termination by dietary and other measures, the cessation of the use of codeine was not followed by any special distress. The effects of codeine on the alimentary canal are remarkable, in that it assuages pain as well or better than morphine, and nevertheless does not check the secretions or peristalsis notably, unless the latter is excessive, as in dysentery. The statement that codeine is simply a 'little morphine,' only differing from the latter in the size of the dose, is an erroneous view, as can be ascertained by any one who closely observes the action of the two drugs."

Codeine in connection with antikamnia has stood the test of exhaustive experimental work, both in the laboratory and in actual practice, and they are now accepted as the safest and surest of this class of remedies. Therefore, "antikamnia and codeine tablets" afford a very desirable mode of administering these two valuable drugs. The proportions, antikamnia 4 3-4 grs., codeine 1-4 gr., are those most frequently indicated in the various neuroses of the larynx, as well as the coughs incident to lung trouble, bronchial affections, grippal conditions and summer colds.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

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Original Communications

REPORT OF SURGICAL OPERATIONS AT THE PRIVATE INFIRMARY OF DRS. CHARLES S. AND SAMUEL S. BRIGGS, DURING ITS SIXTEENTH SEASON, FROM SEPTEMBER 10, 1906, TO AUGUST 1, 1907.

REPORTED BY J. E. BELL, M. D., NASHVILLE, TENN.

(Concluded From July Number.)

Case No. LXI. *Dermoid Cyst of Ovary; Ovariotomy.* Alene P., æt. 9, Dresden, Tenn., admitted January 31, with symptoms indicating, in the opinion of her home physician, acute appendicitis. The patient had been seized with sharp abdominal pains about six days before admission, with marked tenderness in the middle line, rigidity of abdominal muscles and a mass in the median region of the abdomen just above the pubes. Obstinate constipation, continuous nausea and frequent micturition. Diagnosis, ovarian cystoma. On the day of admission, owing to the urgency of symptoms, under chloroform anæsthesia, abdominal section was made in the linea alba. A cystic tumor about as large as a cocoanut presented and was found free of adhesions. The cyst wall was very dark and examination showed that

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the cause of the acute symptoms was a twisted pedicle, three revolutions to the left having taken place. The fluid was evacuated with a small trochar, the unusually long pedicle secured with strong silk braid and the tumor removed. The wound was closed by through and through silk worm gut suture tied after closing the peritoneum with a running suture of catgut. The cyst on examination proved to be dermoid in character, containing a thick lock of hair and other vestiges of cutaneous structures. The patient recovered rapidly and was dismissed February 26.

Case No. LXII. *Pelvic Cellulitis; Hysteropexy and Appendectomy.*—Mrs. A. E. H., æt, 29, resident of the city, admitted January 31. This patient had been taken with severe abdominal pains, high temperature, accellerated pulse and extreme tenderness, several days before admission. Vaginal examination disclosed salpingitis on both sides and marked retroversion of the womb. The bladder was involved, as indicated by painful micturition and hæmaturia. February 5, under chloroform anæsthesia, an incision of three inches was made in the linea alba. The womb and appendages were profoundly congested and adhesions were close and numerous. The adhesions were broken up, the womb restored to normal position and sutured to the parietes by two catgut sutures. A slight wound was made in the bladder wall, but repaired by Lembert suture. The appendix was removed and the stump disposed of by purse string suture. The parietal incision was closed with through and through silk worm gut sutures and serial catgut sutures of fascia and muscles. The wound healed rapidly and the patient was dismissed March 7.

Case No. LXV. *Caries of Tarsus; Amputation of the Leg.*—Willie F., æt., 12 years, Neptune, Tenn., admitted February 20. The patient had received a fall several months prior to admission, the principal injury being to the right foot, which became swollen and tender and after some time an abscess formed, requiring incision. Small abscesses formed at intervals and had to be opened. At the time of admission, the foot was greatly enlarged and presented several fistulous orifices which carried the probe to dead bone. Apparently the entire tarsus was involved in

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strumous degeneration, and it was decided to make an exploratory incision and be governed by the condition of the parts; either to remove the carious portions of the tarsus in an effort to save the foot or if found too extensive for that plan, to make an amputation of the leg just above the ankle. February 21, under chloroform, the parts were exposed by incision and found diseased to such an extent as to require amputation. Lateral skin flaps with circular division of the muscles was the method selected. The patient made a rapid recovery and was discharged March 22.

Case No. LXXI. *Acute Appendicitis; Appendectomy.*—Miss Ellen T., æt., 26, Cheatham County, Tenn., admitted March 4, suffering with an acute attack of appendicitis. The patient had had several attacks previously. On admission, pain and tenderness, muscular rigidity, loss of area of hepatic dulness, temperature 102, pulse rate 110. Under chloroform, incision was made in right semilunar line and peritoneum opened through the sheath of the rectus. A considerable quantity of thin pus was evacuated and the appendix, perforated and gangrenous near tip and containing one enterolith, was removed. Free irrigation with normal saline. Stump of appendix buried with purse string suture. Glass drainage tube introduced into Douglas cue de sac and gauze drain carried along the tube. The wound was closed in the usual manner. The patient did well and was dismissed April 2.

Case No. LXXVI. *Injuries of Hand From Saw; Amputation.*—J. H. C., city, æt. 42, male, admitted March 14, 1907, with hand injured in machinery. The left hand had been caught in a circular saw, making an oblique wound on the dorsum extending from a point anterior to the middle metacarpophalangeal articulation backward through the second metacarpal bone to the first interrosseous space. The saw had divided all the structures through bones and all, but did not involve the palm of the hand. Under chloroform the parts were trimmed up, the index finger amputated, and the parts trimmed so as to make irregular flaps covering the bones. The skin approximated very well and was sutured with silkworm gut. The parts healed well and a useful hand was preserved.

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Case No. LXXX. *Cystic Osteoma of Upper End of Fibula; Excision.*—Miss Sallie P., æt. 24, Smithville, Tenn., admitted March 23, for treatment of growth in the upper external portion of left leg. The tumor had been growing slowly for two years, became inflamed and painful at times, and had attained the size and shape of a goose egg. Indications were that the growth was sarcomatous and the conclusion was that an exploratory incision should be made over the tumor and if found to present the characters of malignancy to amputate the lower third of the thigh. Accordingly March 24, under chloroform, a vertical incision six inches in length was made over the long axis of the tumor. Exposure disclosed a cystic osteoma involving the upper sixth of the fibula. The cyst broke down upon handling, but was removed with the superior fourth of fibula, disarticulating it from the tibia. The wound was closed with interrupted silk worm gut sutures. The wound healed rapidly, but as a result of injury to the external popliteal nerve, there was pronounced extensor paralysis which, though some better, persisted to an unpleasant degree up to the time of patient's discharge, May 10.

Case No. LXXXV. *Recurrent Appendicitis; Appendectomy.*—Madelin W., æt. 16, Cedar Hill, Tenn. Admitted April 2., just recovering from a sharp attack of appendicitis. The patient was put upon liquid and spare diet and the acute symptoms allowed to subside before operating. April 15, under chloroform anæsthesia, appendectomy was performed through the usual incision in the right linea semilunaris. The appendix was quickly found, delivered and removed. The stump was buried with purse string catgut suture. The wound was closed by through and through silk worm gut sutures supplemented by superficial catgut sutures. The appendix was congested and thickened and contained an enterolith in its distal portion. A large clot of blood, evidently the result of the intense congestion, was found in the connective tissue of the omentum, but was not disturbed The patient made a satisfactory recovery and was dismissed May 8.

Case No. LXXXVIII. *Cystic Adenoma of Mammary Gland; Excision.*—Miss Sallie P., æt. 48, Cedar Hill, Tenn. Admitted

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April 7, with growth of some length of time standing, of the left breast. The tumor was hard, painless and about the size of a golf ball. There was no retraction of the nipple and no axillary involvement. Under A. C. E. anæsthesia, the entire gland with all the fascia over the pectoral muscle was removed and the axilla found free of glandular involvement. The incision was closed with silk worm gut sutures supplemented by intervening catgut sutures. The patient was dismissed April 20.

Case No. LXXXIX *Spina Bifida; Excision.*—Litton W., æt. 8 months, Nolensville, Tenn. Admitted April 1, with spina bifida of lumbar region and meningocele about the size of a small orange. The integumental covering was very thin, and the base of the tumor broad. Under chloroform anæsthesia, the sac was carefully dissected free and the neck of the sac found small. The nerve filaments were carefully isolated after opening the sac and evacuating the fluid and the edges of the membranes, carefully approximated with catgut sutures. A second row of sutures, not corresponding with the deeper row, approximated the skin covering. The patient did well for a week during which time, however, there was considerable oozing of fluid, and eight days after the operation convulsions supervened to which the child succumbed. Death was due doubtless to spinal irritation to which was added the general irritation from dentition.

Case No. XCII. *Internal Hemorrhoids and Granular Endometritis.*—Mrs. J. T. W., æt. 40, resident of the city, admitted April 18. This patient had suffered for years with excessive menorrhagia and from hemorrhages from long standing internal hemorrhoids. April 21, under chloroform anæsthesia, the cervical canal was dilated and the uterine cavity curetted with both sharp and dull curettes, removing a considerable quantity of granular detritus. After dilatation of the rectal orifice, four piles were segregated, the lower part of each dissected from the mucous membrane, ligated and excised. One large external pile was removed. Considerable hemorrhage attended the first and second movement of the bowels on April 24 and 28, but afterwards there was none. The patient was dismissed May 4.

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Case No. XCVI. *Epithelioma of the Left Eyelid; Excision and Canthoplasty.*—H. P., Jr., æt. 38 years, male, Waverly, Tenn., admitted April 27. This patient had epithelial ulcer about the size of a silver quarter just below the outer portion of the lower eyelid, which had been cauterized several times by strong caustics applied by cancer doctors. The ulcerated surface was irregularly triangular with base just under the edge of the lid, the edges were inducated and the base covered by unhealthy granulations. A marked ectropion was present, due to cicatricial contraction. April 28, under chloroform anæsthesia, the growth was removed by V-shaped incision. The malar-bone was found softened and was freely curetted. Adhesions were divided and the outer arm of the V was extended horizontally outward about an inch and a flap dissected free of the underlying parts so as to slide inward and fill the gap. The antrum of Highmore was opened, but the mucous membrane was left intact. The gap was well covered by the flap slided inwards from the outer side and the wound sutured with silk worm gut sutures supported by adhesive plaster. A gauze drain was inserted in the lower part of the wound on account of a few drops of pus which had oozed out of the deeper parts of the wound. The wound healed by first intention, the ectropion was entirely relieved and the patient was dismissed May 6.

Case No. XCVII. *Fibroid Tumor of Supraorbital Region; Excision.*—Mary G., æt. 9, White's Creek Pike near city, admitted April 28, with small growth in outer supraorbital region. The tumor was about the size of a silver quarter, disc-shaped, painless and movable. April 28, under chloroform, by a straight incision about an inch and a half in length, the tumor was exposed and with considerable difficulty dissected out. The wound was closed with continuous catgut sutures and the usual dressings applied. The wound healed by first intention.

Case No. XCIX. *Schirrus of Mamma; Excision.*—Mrs. J. M. P., æt. 65 years, Cedar Hill, Tenn., admitted May 1, with growth in left mammary gland. The patient had noticed a small nodule in the breast several years previously which grew slowly in size, became painful and caused deterioration of her general health.

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On admission there was present marked cachexia. The growth was situated in upper external quadrant of the gland. Considerable enlargement of axillary glands. The nipple was retracted. The growth was hard, irregular and nodulated and several nodules were inflamed and on the verge of breaking down. Under A. C. E. anæsthesia May 2, the gland was removed by elliptical incisions and one arm of the incision extended into the axilla and all the glands, about twenty in number, removed. The incised edges approximated easily and were united with silk worm gut sutures supplemented by superficial catgut sutures. The wound healed throughout by first intention and the patient was dismissed May 23.

Case No. C. *Recurrent Appendicitis; Appendectomy.*—R. M. S., male, æt. 32 years, Harriman, Tenn., admitted May 3, just after recovering from an acute attack of appendicitis. Marked circumscribed tumor at the site of the appendix, with tenderness and muscular rigidity. Under A. C. E. anæsthesia, May 4, an incision was made through parietal walls over the center of the swelling the principal mass being to the inside of the incision. The mass was incised and a small quantity of pus evacuated. The appendix was not disturbed as the abscess cavity was well walled off and a search might have entailed general infection. Patient required strychnia and electricity during anæsthesia. The abscess cavity was packed with gauze and wound left open. The patient made a rapid and uneventful recovery and was dismissed, with wound nearly cicatrized, June 1.

Case No. CIII. *Neuralgia of Superior and Inferior Maxillary Nerves; Excision of Infra-Orbital and Inferior Dental Nerves.*—Dr. M. A. C., æt. 62 years, Ethridge, Tenn., admitted May 6, suffering with chronic neuralgia of the face that had long resisted all treatment. The condition was extremely painful, the patient suffering with frequent paroxysms of intense suffering. It was decided to excise the principal nerves affected and if relief was not obtained, at a later period remove the Gasserion ganglion. May 12, under A. C. E., a two-inch incision was made along the edge of the orbit, the infraorbital nerve exposed at the foramen, the floor of the orbit opened along the groove and the nerve

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followed up and divided far back in the orbit and removed, about two and a half inches being taken away. The inferior dental was approached by incision over the ramus and trephining that portion of the inferior maxilla, the nerve exposed and about two inches of the nerve removed. The upper portion of the dental canal was plugged by driving in a small fragment of fresh bone. The wounds healed rapidly and the patient was entirely relieved, leaving for his home May 22.

Case No. CV. *Stone in the Bladder; Medio-Bilateral Lithotomy.*—W. J. A., male, æt. 69, Pulaski, Tenn., admitted May 8, suffering from recurrent vesical calculus. A large stone had been removed by medio-bilateral lithotomy six years previously, from which had resulted a persistent recto-urethral fistula. Examination with sound detected presence of calculus in the bladder. Under A. C. E., May 19, medio-bilateral lithotomy was performed, the incision being carried through the cicatrix of the former operation. The stone was found and removed after fragmentation. The right lobe of the prostate gland was found enlarged considerably, but was not incised more than was necessary as a step to the operation. The recto-urethral fistula, which was superficial, was opened into the rectum. Frequent irrigation with boracic acid solution was employed. The patient progressed for ten days very satisfactorily, but conditions arose during that time which rendered a second operation necessary as will be described further on in this paper under case No. CXIV.

Case No. CIX. *Stone in the Bladder; Medio-Bilateral Lithotomy.*—Connie S., æt. 14 years, Barren Plains, Tenn., admitted May 20. The bladder had been searched by a sound by his home physician, and the presence of calculus in the bladder demonstrated. After some preparatory treatment, under chloroform anæsthesia, medio-bilateral lithotomy was performed as described in former cases in this paper and a small calcic oxalate calculus, weighing about 16 grains was removed. Enough hemorrhage resulted from the incision to require the use of a drainage tube in the bladder, and this was held in situ by a loose packing of iodoform gauze. The patient made a rapid and uneventful recovery and went home June 10.

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Case No. CXII. *Schirrus of Mammary Gland; Excision.*—Mrs. M., æt. 79 years, near Una, Tenn., admitted May 28. There was present in the upper external quadrant of the left breast, a hard, nodular, irregular, painless growth, evidently carcinomatous. May 30, under A. C. E., the growth was excised with elliptical incisions and the fascia overlying the pectoralis major muscle was carefully dissected off. The axillary space was opened and only one gland, about the size of a hickory nut, found and removed. The wound was closed with silk worm gut sutures with interval superficial catgut sutures. The wound healed by first intention and the patient was dismissed June 14.

Case No. CXIII. *Internal Hemorrhoids; Ligation.*—Dr. W., æt. 52, Wilson County, Tenn., admitted May 30. This patient had been a sufferer from internal piles for thirty years, and the suffering incident to that disease had caused him to form the morphine habit, so that when admitted he was taking daily from eight to ten grains. Under A. C. E., May 30, the sphincter was paralysed by dilatation and the hemorrhoids excised after dissecting and ligation according to Allinghams method. The patient was entirely relieved and went home June 11.

Case No. CXIV. *Medio-Bilateral Lithotomy.*—W. J. A., æt. 69, Pulaski, Tenn., admitted May 8, and operated on for stone in the bladder by the medio-bilateral method for stone in the bladder, as reported in case No. CV. In irrigating the bladder about ten days afterward the presence of another stone was detected. Under A. C. E. anæsthesia, May 30, the wound was dilated with the finger and a large quantity of calcic phosphate debris removed, which in its entirety would have made a stone greater in volume than the first one removed. Doubtless this calculus had been located in the prostate gland and overlooked at the first operation. The calculus had evidently been dislodged into the bladder by the manipulations necessary in irrigation or by pathological processes taking place in the wound. Suppression of urine supervened three days after this second operation, and the patient died June 10.

Case No. CXV. *Multiple Cervical Lymphadenomata; Excision.*—Camille H., æt. 19, female, resident of the city, admitted

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June 4. This patient had, on both sides of the neck, enlarged glands extending from the mastoid process and under the jaw as far inward as the chin and as far down as the clavicle. On the right side was a cicatrix marking the site of an operation performed for removal of the glands several years before. The patient's health was excellent with the exception of menstrual irregularity, but the disease produced an unsightly deformity. June 9, under chloroform anæsthesia, an incision was made along the anterior border of the sterno mastoid muscle, extending from the space back of the angle of the jaw nearly to the clavicle, exposing the carotid sheath, the external jugular vein having been dissected out and divided between hemostats. The glands, to the number of thirty, ranging in size from a pea to a small orange, were successively enucleated. The internal jugular vein was opened in tearing away a small gland and secured in hemostatic forceps. Before closing the wound the opening in the vein was closed with a lateral ligature of catgut. Very little blood was lost. The wound was closed by subcuticular catgut suture and sponge pressure used in the dressing. Healing took place promptly, though a small abscess formed at the site of the first operation. The operation required about two hours, and it was thought best to defer operation on the other side until the patient had recovered from the first.

Case No. CXVI. *Strumous Knee Joint; Amputation of Thigh in Lower Third.*—John S., æt. 29, Waterview, Ky., admitted June 4. This patient had suffered with chronic affection of left knee joint for a number of years. The knee was considerably swollen, the enlargement hard and irregular. Some weight could be borne on the limb, but the patient had to use crutches. At no time had the inflammation caused abscess. It was decided to lay open the joint and if the condition of the parts justified it, excise the joint; if not, resort to amputation. Under A. C. E., first, then chloroform, June 10, the joint cavity was exposed by anterior curved incision and the joint structures found irreparably diseased. Accordingly, amputation in the lower thigh of the thigh, lateral flaps, was done by transfixion. Muscles sutured with buried catgut. The flaps were joined, without drainage, with silk

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worm gut sutures supplemented by superficial catgut sutures. Healing took place without pus, and the patient was dismissed July 10.

Case No. CXXI. *Mastoid Abscess; Operation.*—T. A. H., æt. 62, male, Goodlettsville, Tenn., admitted June 14. For some weeks he had been troubled with inflammation and free discharge from the left ear. The mastoid region became tender and swollen, and the parts of the neck adjacent became œdematous and infiltrated. June 14, under A. C. E. first, and then chloroform anæsthesia, the mastoid process was laid bare and an opening made into the mastoid antrum with a carpenter's gimlet and enlarged freely with chisels and gouges. A good deal of pus was evacuated from beneath the skin and the cells curetted out with bone curettes. The abscess cavity was packed loosely with gauze and the wound treated openly. The tissues of the neck became infiltrated with pus for a considerable area, necessitating free counter openings and for some time pus in large quantities was discharged, but at the time of his dismissal, July 6, this was gradually becoming less, and the patient was in a fair way toward recovery.

Case No. CXXIII. *Laceration of the Cervix; Trachellorraphy.* Mrs. R. C. I., æt. 33 years, resident of the city, admitted June 17, just after a miscarriage of six weeks. The patient had an extensive laceration of both sides of the cervix and this evidently was the cause of the abortion. Under chloroform June 18, the uterine cavity was thoroughly curetted. The cervical tear was pared and the rent sutured with five silk worm gut sutures, two on the right and three on the left. The sutures were removed on the 12th day, and union found perfect. The patient was dismissed July 2.

Case No. CXXVI. *Perineorrhaphy; Abdominal Section; Removal of Parovarian Cyst. Hysteropexy.*—Mrs. C. Mc., æt. 36, Waverly Place, Tenn., admitted June 22. The patient had for some years suffered from uterine trouble. Examination discovered old partial laceration of perineum, retroversion of the womb in extreme degree and an ill-defined enlargement in the

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right broad ligament. Under A. C. E. anæsthesia, June 23, the uterine cavity was curetted thoroughly, the perineum repaired after the method of Doleris, the abdomen opened in the middle line by three-inch incision and the womb found markedly retroverted. A small parovarian cyst about the size of an orange was discovered in the right broad ligament and was enucleated. The uterus was sutured by strong catgut to parietes. The wound was closed in the usual manner. The patient was dismissed July 13.

Case No. CXXX. *Epithelioma of Lower Lip; Excision.*—J. W. W., æt. 58 years, Columbia, S .C., admitted June 30, with hard, ulcerated growth of the lower lip at the junction of the outer and middle third. The ulcer was about as large as the little finger nail, its surface scabbed over and its base indurated. Several applications of caustic had been made at different times. Under cocaine anæsthesia, a V-shaped section of the lip was made, the base of the section being about three quarters of an inch in length. The edges were approximated with one hare lip pin and three silk worm gut sutures. Healing was perfect, and the patient was dismissed July 5.

Case No. CXXXI. *Carcinoma of Cervix Uteri; Vaginal Hysterectomy.*—Mrs. W. M .B., æt. 49, Huntsville, Ala., admitted July 1. The patient gave a history of excessive uterine hemorrhage extending over a number of months, a good deal of pain at times and a constant sanious, badly smelling discharge from the vagina. Examination disclosed a well marked carcinoma of cervix, indurated, ulcerated and bleeding excessively upon touch. Under chloroform anæsthesia, July 2, vaginal hysterectomy was done. The vessels were ligated with silk braid ligatures on the two sides. The vaginal wound was closed by two catgut sutures and the vagina loosely packed with gauze. The ligatures came away on the 14th day. The patient returned home at the end of five weeks.

Case No. CXXXVI. *Internal Hemorrhoids; Ligation.*—J. U. S., æt. 40 years, male, Springfield, Tenn., admitted July 8, for treatment of internal hemorrhoids of long standing. Protrusion of the mass was the most troublesome feature. Under chloroform, July 9, the sphincter was paralyzed and five large hemorr-

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hoids ligated. A troublesome condition following the operation was retention of urine, persisting for some days and resuiring the catheter at regular intervals. The patient was dismissed July 22.

Case No. CXXXVIII. *Cervical Lymphadenomata; Excision.*—Camille H., æt 19, city, operated on for removal of glandular tumors of the right side of the neck as described in case No. CXV. July 10, under chloroform, the left side was operated on using the same length and position of incision as in the first operation. The glands along the internal jugular and under the sterno-mastoid muscle and under the inferior maxillary bone to the number of forty, were removed without accident. In addition a bunch of glands consisting of about fourteen, were removed through a two-inch incision from right axilla. The neck wound was closed by subcuticular suture. The parts healed rapidly and the patient was dismissed with only linear scars, July 22.

Case No. CXL. *Incised Wound of Wrist; Ligation of Radial and Ulnar Arteries.*—H. N., æt. 19, male, resident of the tity, admitted July 12, with an extensive curvilinear wound of palmar surface of the arm just above the wrist made by a flying fragment of glass from a large five-gallon bottle. Without anæsthesia, the radial and ulnar arteries were, with a little dissection, isolated and ligated with catgut on each side of the lesions in their walls, the divided tendons were accurately sutured and the skin wound closed with continuous catgut suture. The arm was placed on a palmar splint and the patient sent home. The result was satisfactory and the flexor function of the fingers will be nearly perfect.

Case No. CXLII. *Chronic Appendicitis; Interval Operation.*—J. E. D., æt. 28, resident of the city, admitted July 14, suffering from chronic appendicitis. This patient had suffered a number of attacks of greater or less severity and under advice awaited the interval period for operation. The region of the appendix was tender, that organ could be palpated and the usual digestive disturbances were in evidence. July 14, under chloroform, the appendix was removed through the usual incision and the stump

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buried with purse string catgut suture. Through and through silk worm gut sutures were placed, the peritoneum closed with continuous catgut sutures and the silk worm gut sutures then tied. The appendix was large, its coats thickened and evidences of previous attacks of inflammation marked. The patient made an uninterrupted recovery and was dismissed on the sixteenth day.

Case No. CXLV. *Rupture of the Perineal Urethra; External Urethrotomy.*—W. R., æt. 25, resident of the city, admitted July 20. While at work, he fell astride of the edge of an open goods box and ruptured the urethra. The usual symptoms of hæmaturia, retention of urine and local signs presented. Attempts to relieve by catheterism were futile and on the day of admission, under chloroform, perineal section was done. An incision, one and a half inches in length, was made in the median line upon the end of a staff passed as far as it would go into the urethra. After some search, the vesical end of the urethra was found and a tube was guided into the bladder over a blunt gorget and the wound packed with gauze. Entire relief was afforded, the urine passing copiously through the tube. The tube came away on the third day and drainage stopped so that the gauze had to be removed. The removal of the gauze was followed by hemorrhage, which necessitated the use of an anæsthetic and reinsertion of tube and packing. The tube and packing came away in 36 hours, and after being out two days during which time the wound was healing and the drainage clear, a severe hemorrhage took place which again necessitated the reintroduction of the tube under chloroform and drainage. At the present writing the patient is doing well with every prospect of recovery.

Addenda.—Among the numerous minor operations not reported above may be mentioned six cases of tonsillotomy, three bone felons, paracentesis of abdomen for splenic abscess six times, four cases of circumcision, three of avulsion of toe nail, two cases of extraction of pistol bullets, a number of cases of incised wounds of different parts of the body, fractures of arm, one dislocation of shoulder joint, one case of extraction of foreign body from the œsophagus and one of grain of corn from the nose.

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Can Cows Drinking Water Infected with Typhoid Fever Germs Communicate This Fever to Individuals Who Drink Their Milk?

BY R. A. GRAINGER, PARIS, TENN.

In 1891 I was called to see a colored family consisting of husband and wife with six or eight children. I found two or three of the children quite ill and learned they had been so for only a short time, two or three days. Within a week or ten days from the time these children became sick, three or four more were ill with what I considered rather severe typhoid fever. These cases presented to my mind rather well marked clinical pictures of typhoid fever. The details of the clinical histories I do not now remember, but they each ran about the typical course of typhoid fever.

These children had been no where and there had been nothing brought to their home, so far as I could ascertain, that could probably bring the poison to them. There was no case of typhoid fever in that neighborhood and none developed later. They used spring water from a spring that was used by other families in this neighborhood, none of whom developed typhoid fever.

I learned these children all drank milk and that the cows drank water of small creek that ran nearby night and morning, as they were driven to and from the pasture.

Some time before and after these cases developed there was considerable typhoid fever in and around Paris which drained into this creek a few hundred yards above where these cows crossed and drank.

These cases developing in so short a time caused me to feel their infection was from a common source. Not being able to find any plausible mode by which they could have been infected, I wondered if the cows' milk could have been infected by the cows drinking the creek water, which I felt was infected and the children received the infection through this milk which they drank.

I investigated all the literature I had as to the modes of conveying typhoid fever infection to individuals and I found no

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mention of this as a possible mode. I wrote to several prominent physicians in different parts of the United States asking if, in their opinion, it was possible or probable that cows' milk could be infected with typhoid fever poison by their drinking water contaminated with this poison and individuals who drank their milk become infected and develop typhoid fever, and if they could inform me where I could find any literature bearing directly upon this subject. None knew of any literature, some doubted whether it could and some thought it very probable.

While there was no positive evidence in these cases, the circumstances were such as to cause me to believe they were infected in this way, and I have since regarded this as a probable means of conveying this infection. I have since run upon no cases so convincing to me.

MEDICO-LEGAL.

BY E. S. M' KEE, M.D., CINCINNATI, OHIO.

Dr. Edward R. Taylor, physician and lawyer, San Francisco, Dean of Hastings Law School of the University of California, has been elected Mayor of San Francisco, vice Schmitz, in jail. The last arbitrary act of Schmitz was to turn out the Board of Health because it did its duty in opposition to his commands in acknowledging the presence of the plague in the city and taking active measures to suppress it. We hope this medico-legal combination will prove a benefit to the stricken city.

JUDICIAL CRIMES.

It has been frequently claimed, and is probably largely true, that criminal law has made no progress in two hundred years, and on this account is in no condition to be compared with medicine. When a sick man is sent to the hospital he is not sent for a term of months or years, but till he is cured. When a man is cured of a moral disease in a prison he is not let out, but is kept there and the treatment, or punishment continued for a stated time. Even when this time has expired and he is released, the public, no difference how severe his treatment or perfect his

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cure, continue the treatment or punishment by ostracising him more or less for the remainder of his life. True it is that a culprit is seldom cured of moral disease in a prison yet that should be the object of his incarceration. Doctors do not say that a man with typhoid fever must go to the hospital or the bed for three years, a man with the smallpox ten years, a man with appendicitis twenty years, unless he has money, a man with a boil 30 days, and a man with a boquet of boils, a carbuncle, ninety days. The penitentiary is full of prisoners suffering quite as much from the sins of the judges who condemned them as their own. The judge often has no means of knowing the circumstances of the case, what led up to it, the annoyance, the aggravation, the suffering and want, which lead up to committing, in fact, forced the deed. Had he been in the culprit's place, had his surroundings and bringing up, would he have done differently? He does not know what hidden mental or physical defect may have preyed upon him.

A JUDGE'S OPINION OF MEDICAL WITNESSES.

Mr. Justice Brown, of the United States District Court, in a paper before the Rhode Island State Medical Society, said that it was a common opinion among judges in his state that physicians, as a rule, made good witnesses, that they were honest, clear in their statement and showed a trained mind. There are, however, in the medical profession, as in the legal, a very small minority who are dishonest, and these men present a substantial problem. It is not merely a problem of the medical expert, but a problem of the liar on the witness stand. The special problem of the liar who is given the privilege of expressing his opinion on the witness stand on obscure questions. The problem is practically the same in all branches of expert testimony. The dishonest medical expert must be dealt with as any other dishonest witness, as an individual.

THE ETHICAL SIDE OF PROFESSIONAL SECRECY IN RELATION TO VENEREAL DISEASE.

Venereal disease is without doubt considered by modern medical science as one of the greatest scourges the human race has to

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combat. That the one formerly considered comparatively trivial, gonorrhea, is at least in its results the more to be dreaded of the two. That the sin of the infected, is constantly visited upon the innocent and entails on countless thousands sterility, insanity, and a host of maladies to the very great danger to the state. Death would be more welcome than life to many sensible and honorable persons polluted by these shameful diseases accompanied by the knowledge that the evil may be transmitted to children. Thou shalt do no murder is the highest law, human or divine. Law, however, permits us to kill under certain circumstances. For instance, in self-defense. Abortion, criminal, if committed with evil intent, is lawful if performed to save the mother's life. Now if this great leading law, "Thou shalt not kill," is subject to limitations, it seems that the duty of physicians to conceal what they have learned of a patient's condition would be overshadowed by the, to them, undoubtedly paramount duty, viz: the saving of life and the preservation of health. It seems also, from a lawyer's view of the case, that where the preserving of a patient's secrets conflicts with the higher duty to the individual or the state, the former should yield. In law he who aids or abets a crime is himself a criminal. Morally he who consents to a wrong which he might prevent, is a criminal. He who communicates a venereal disease inflicts a very great bodily injury upon that person and a wrong to the state. The law justifies homicide committed in resisting great bodily injury and would thus justify the killing in order to prevent willful infection.

The articles of war of the United States Army expressly provide that an officer or soldier committing an outrage on a woman in an invaded district, may, if caught in the act, be shot on the spot or may be punished by court-martial by death. Poisoning weapons or wells or sending out infection in any way is forbidden in civilized warfare. If this is true with reference to an enemy, why is not poisoning the springs of life in those most entitled to love and protection equally so? Upon what ground is any one who intends to deliberately spread contagion entitled to any protection? This is indeed a hard question, and much

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more difficult from the side of a physician than that of a lawyer.

It would seem that the physician knowing that an infected patient is about to carry his contagion to a pure person, and perhaps to persons unborn, is justified in both law and morals in preventing the proposed wrong by disclosing his knowledge if no other way is open.

Under our system of jurisprudence medical men reporting venereal diseases might be held liable in two ways. First, it is slanderous to say, and libelous to write, that a person is so affected. For both slander and libel a civil action lies against the defamer in which, as a general rule, the truth is a complete justification of defense. For libel i. e. written defamation, a criminal action also lies, to which it is a defense to show that the libelous matter is true and was published from good motives to justifiable ends.

Creosote, even though administered in capsules on a full stomach, is liable to go to pieces against the stomach wall and cause considerable irritation. It is best given as follows: Creosote, 1.00; charcoal, 2.00. Mix and allow to dry without heat for half an hour and put up in konseals and administer on a full stomach.

Trymol 1-4000 will keep cocaine solutions.

Acetanilide 1-5,000 will keep peroxide of hydrogen solutions.

Soluble Iodine.—The following mixture is soluble in water in any proportion and is stable: Iodine, 6; glycerine, 25; water, 75. Mix this solution with water in a bottle in the proportion of one to seven or a drachm to the ounce, and a teaspoon of this will represent a half a grain and should be taken in at least a half glass of water.

Ambitious doctors in Cincinnati assert that there is no chance to satisfy their ambition unless they have a father, brother, uncle or some relative in the holy of holies to "wire" for them. That there is some truth in this claim one needs but to look over

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the lists of names constituting the faculties and staffs of the city. However true this may be of Cincinnati, it is more so in Philadelphia, which city, Chicago doctors say, is the only one in the United States slower than Cincinnati. In Philadelphia we have Cohens, Mussers, Pancoasts and Da Costas occupying enviable positions even unto the third and fourth generation. The most decided case of one doctor traveling on another's reputation occurred recently. Dr. H. J. Whitacre, one of our coming surgeons, who is "going some," was seeking surcease from surgery at the sea side. He was wired by a Kentucky doctor to come and see a case in consultation with him. Dr. Whitacre pleaded vacation, but the Kentucky doctor was insistent, saying no one else could save his patient. Flattery fanned his fevered brow and he went. After a tiresome journey he reached the Kentucky doctor and was met with a stare and the exclamation, "You are not Dr. Whittaker." His patient was suffering from tuberculosis and he was hunting the well known champion of tuberculin, Dr. J. T. Whittaker, since seven years dead.

Recumbency in the Treatment of Infantile Paralysis.

BY ADONIRAM B. JUDSON, M.D., NEW YORK CITY.

In the ever-changing treatment of disease the influence of environment is receiving unusual attention, as is seen in the management of tuberculosis of the joints. The influence of the lapse of time is also better understood. Medicines are given in small doses for very long periods, and the effects of time on the body are more clearly seen to influence the course of disease and the action of remedies.

In the treatment of infantile paralysis I propose a method which relies exclusively on the influences of environment and the lapse of time. It is applicable only in the very early stage, before the case is likely to be seen by an orthopædic surgeon. As soon as the disease is recognized I would limit the patient to the recumbent position till there is no possibility of further recession of the paralysis. The period of spontaneous recession extends over

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several months. During this time the difficult task must be undertaken of keeping a child, well in every other way, off his feet at an age when he should be learning to walk. In some cases 18 months should be occupied in this way. The common belief that such a patient requires exercise, especially of the affected limbs, will give rise to criticism and objections. A simple argument will not prevail in the family circle, and the physician's word will hardly prevent the little patient from having many a romp. And when the case ends there will be differences of opinion. If some lameness results, it may be said that the patient should have had more exercise, and if there is no disability at all, after the strict observance of recumbency, it may be said that there had been very little the matter with the child.

The argument is as follows: It will be recalled that the ill effects of joint disease are seen more commonly in the lower extremities than the upper, because tuberculous action is subject to resolution in the epiphyses of the shoulder, elbow and wrist, but often goes on to destruction of the articulating surfaces of the hip, knee and ankle. And when it is noted that the arms are free while the legs bear the weight of the body it is reasonably inferred that the joints of the lower extremities when affected, or even suspected, should be protected by either recumbency or appropriate apparatus. The conclusion is a plain proposition and needs no discussion or verification. It shares the simplicity of Jenner's argument when he traced the relation of cause and effect and prescribed vaccination. In other fields Finlay, walking with his eyes open, apprehended the relation of cause and effect and prescribed the sequestration of the mosquito.

The necessity of reforming the environment of the lower extremities having been derived from clinical observations of joint disease, can practical conclusions be drawn in a similar manner from observing the course of infantile paralysis? Disability from this disease is seen eight times as often in the lower as in the upper extremities, and yet in the early stage the paralysis is found in all parts of the motor nervous system. The muscles of the recumbent patient are in very moderate use and in a position entirely favorable to spontaneous recession of the paralysis. The

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arms and hands retain this advantage when the patient is erect, but the impaired muscles in the legs and feet give way at once when they meet the resistance of the weight of the body. They rapidly become elongated and attenuated, and could not well be placed in an attitude more destructive of the possibility of restoration.

When prescribed recumbency shall give to all parts the same environment, recession of paralysis will be equally encouraged in the lower and upper limbs, the disproportion of 8 to 1 will disappear, and the sum of deformity from this disease will be materially reduced.

The value of the method is thus *proved,* but it is not easy to show that one is better than another. It may always be said that a case cited in behalf of a certain method may have been one that would have done well under any treatment. Tables of carefully recorded cases might lead to correct estimates, but studies of this kind are difficult and have not escaped criticism. Dr. Gaillard Thomas said with wit and wisdom that if there is anything more misleading than facts it is figures. Medicine and surgery are still outside of the realm of exact science. Therefore, we welcome every logical and reasonable resource of prevention and treatment.

Passive motion, resistance exercises, electricity, massage, local applications and judicious medicine should be continued They cannot interfere with the treatment proposed, and their observance may make it easier persistently to maintain recumbency the most important agent of all.

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Proceedings of Societies

American Proctologic Society.

(Ninth annual meeting, held at Atlantic City, N. J., June 3 and 4, 1907, the President, Dr. Samuel G. Gant, in the chair.)

The following officers were elected: President, A. Bennett Cooke, M.D., Nashville, Tenn.; Vice-President, Louis J. Krouse, M.D., Cincinnati, Ohio; Secretary-Treasurer, Lewis H. Adler, Jr., M.D., Philadelphia, Pa., and the Executive Council: J. Rawson Pennington, M.D., Chicago, Ill.; Chairman, Samuel G. Gant, M.D., New York City, N. Y.; A. Bennett Cooke, M.D., Nashville, Tenn.; Lewis Adler, Jr., Philadelphia, Pa. The place of meeting for 1908 is Chicago, Ill., the time to be announced later.

ELECTION OF MEMBERS.

The following were elected members of the Society: Dr. Jerome M. Lynch, of New York City; Dr. Jas. A. McVeigh, and Dr. J. A. MacMillan, of Detroit, Mich.

The following is an abstract of the principal papers read:

PRESIDENT'S ADDRESS.

The President, Dr. Samuel G. Gant, of New York City, said "that the annual meeting of the Society were like a post-graduate school where advanced information in proctology could be obtained by the members. He considered it unwise to admit to membership in the Society the general surgeon and young rectal specialists of less than five years experience in this special work, because the membership would become too large and the papers contributed by them would not meet the requirements.

He maintained that the proctologist of the future, in order to be successful, must have a thorough literary and medical education, a hospital training and clinical facilities, and that he must be clever, industrious and persistent. He emphasized the necessity of educating both the profession and the laity ,as to the re-

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markably improved methods now employed in the handling of patients suffering from diseases in the lower bowels. He also said it was the duty of the proctologist to demonstrate by his work and writing that most tubercular fistulæ were curable and that the curing of ordinary fistulæ did not tend to bring about lung or skin affections as was formerly believed; that local incontinence does not follow fistula operations, when the muscle is cut at a right angle and the wound is properly dressed; that many rectal diseases, such as fissures, ulcers, small fistulæ and some hemorrhoids can be operated upon under local anæthesia; and that in the majority of instances, constipation and chronic diarrhea are curable by local and surgical measures.

Finally, he emphasized the fact that the etiology of many discomforts, nervous and reflex phenomena, usually attributed to the genital organs is frequently to be found in some pathologic process located in the sigmoid rectum or anus."

REPORT OF PROCTOLOGIC LITERATURE FROM JUNE, 1906, TO JUNE, 1907.

Dr. Samuel T. Earle, Baltimore, Md., read his report on Proctologic Literature, covering a period from June, 1906, to June, 1907, in which he said, "that while there has been nothing startling in Proctologic literature in the past twelve months, your committee is gratified with the steady progress in this branch of medicine and surgery, as has been reflected in the literature on this subject. Especially gratifying have been the recommendations for the radical treatment of carcinoma of the upper rectum and sigmoid, as set forth in the papers of Samuel G. Gant, W J. and C. H. Mayo, and James P. Tuttle, in which they all recount the combined advantages of the abdominal and perineal routes. which we think will greatly lessen the liklihood of recurrences. and increase the number of permanent cures. We note with pleasure the systematic efforts that are being made in the study of the etiology of pruritus ani. The paper of Wallace of London in 1905 on the study of this question, stimulated the efforts of others in this direction, and we find an excellent paper by J. C. Hill of Boston, on the same, in the *Boston Medical and Surgical Journal,* 1906. In this article, he takes the stand with Wallace

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that there is always a cause for this malady in which the pruritus is only a local symptom. We quote him as follows: "Pruritus ani is the symptom caused by unnatural moisture or discharges, produced either by lesions about the anus or by congestion, or some pathologic condition in the rectum or sigmoid. It is due to one of five causes. First, and by far the most important, are superficial ulcerations, or abrasions of the anal canal. Second, catarrhal diseases. Third, external hemorrhoids. Fourth, inflammation or irirtation of the crypts of Morgagni. The free borders or valves of these crypts consist chiefly of nerve fibres, ganglion cells and connective tissue. When inflamed or infected, they may give rise reflexly to pruritus ani. The writer calls attention to the tits which project from the margin of these valves as accessory sense organs. When hypertrophied or elongated they cause many distressing symptoms about the anus, viz.: creeping, crawling sensations and itching. Fifth, small polypi of the anal canal."

It is not only necessary to remove the exciting cause of the disease, but also to direct appropriate treatment to the unnatural conditions of the skin. In this connection your committee is glad to be able to report a number of cases of the aggravated form of this disease, which had failed to respond to the usual local and constitutional methods that were successfully treated by Dr. Ball's recommendation of dividing the anal nerves. These have been reported by Drs. Mattin and Earle.

Dr. Charles B. Kelsey calls attention to the office treatment of hemorrhoids by puncture with the electric cautery. The method is to make numerous punctures with a pointed cautery to the internal hemorrhoids. This method has been used for the past ten years in lieu of that by injection, with most satisfactory results, and without any unfavorable effect. For the details of the method I would refer to his article in the *Therapeutic Gazette* for March 15, 1906. The reviewer would respectfully report with reference to this suggestion, that about ten years ago he tried in a number of cases, but with only temporary success where the hemorrhoids were large. It answered very well in small capillary hemorrhoids. J. A. Harwell, in the *Annals of Surgery,* Philadelphia, for 1906, Vol. 43, page 146, reports a case of resection of the rectum for

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syphilitic stricture, with end to end anastomosis. As might have been predicted, it recurred, and while it was necessary to continue dilating, he was not hopeful of results. Your committee would remind its members that such radical measures seldom accomplish the desired results, as recurrence is almost inevitable.

ADDITIONAL EXPERIENCE WITH A NEW PROCEDURE IN OPERATING FOR ANO-RECTAL-FISTULA.

By Dr. J. R. Pennington, Chicago, Ill., who said: "I have found the employment of the seton in operating on cases of anorectal fistula greatly aids in preserving the contour of the anus and the functions of the sphincter muscles.

"The technique in using the seton is as follows: After all of the fistulous tracts external to the sphincter are divided a probe-pointed director is passed into the bowel through the remaining tract and an incision made on its distal side. This incision should extend far enough distally to divide all or a part of the fibers of the external sphincter and in such a direction as to locate the transferred internal opening at or near the anal margin. Then, turning the knife, make an incision—Salmon's 'back-cut'—on the proximal side of the tract. A seton is then passed through the opening entering the bowel and tied loosely around the tissues remaining and undivided.

"The wound is dressed as after the ordinary incision operation for fistula. At the end of twenty-four to thirty-six hours the wound is re-dressed, care being taken to dress it so that the opening entering the bowel will be made to heal from the proximal toward the distal side. The object in doing this is to advance the final fistulous tract as far distally (toward the skin) as the case will permit, so that, if possible, it will pass through or distally to the fibers of the external sphincter, when the healing process is complete.

As a rule, the enlarged tract entering the bowel soon closes, with the exception of the part through which the seton passes. As soon as this has occurred the seton may be removed, and by the time the external wound is healed the tract entering the bowel will possibly have closed also. Should it not, at any time later, this little tract may be dissected out and the remaining fibers of

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the muscle sewed together, thus preserving the contour of the anus and the functions of sphincters."

OCCULT HEMORRHOIDS FROM THE RECTUM.

By William M. Beach, Pittsburg, Pa., who stated: "(1) Occult blood in the stool indicates disease high up in the gastro-intestinal tract. (2) Accompanied by certain rational symptoms as pain localized, the origin of occult blood can be noted. (3) The discovery of blood in the stool may enable us to predict hemorrhage or prevent disaster. (4) The most frequent sources of occult blood are in the order named: stomach, duodenum and caput coli. (6) The aloin-turpentine test as practiced by Dr. J. Dutton Steele, of Philadelphia, is recommended. (7) Proctologists should make an examination for occult blood a routine practice in cases of anæmia accompanied by diarrhœa or constipation."

ETIOLOGY AND SYMPTOMS OF FISSURE.

By Dr. C. F. Martin, of Philadelphia, Pa., who said: "The fissure is usually situated posteriorly and directly over the 'white line' of Hilton, due to the arrangement of the fibers of the external sphincter and to the fact that the anal canal has less elasticity directly over that line. Most fissures start as the result of the distention of the canal by hard feces and excessive straining at stool. Those situated anteriorly are often seen after confinement due to the pressure of the fetal head upon the perineum.

"The sentinel pile is noted in most cases if the fissure has been present for any length of time. It is a simple inflammatory hypertrophy. Hypertrophy of the anal papillæ does not appear to be an important factor in the causation of fissure. True hypertrophy of the sphincters is rarely seen, but in its place we find an excessive irritability of the external sphincter.

"The distinctive symptom of this disease is pain or sphincteralgia, preceded by a 'pain interval' of from one minute to an hour, during which time the patient has comparative comfort. The pain is caused by spasm of the sphincter compressing the nerves in the ulcer. This contraction interferes with the perianal circulation and renders the inflamed nerves more sensitive. The

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'pain interval' is caused by a temporary improvement in the perianal circulation produced by the straining efforts at stool.

"The constipation of fissure often precedes the formation of the ulcer, an irritable sphincter being the underlying factor in the production of this condition. The constipation increases after the formation of the ulcer due to the fear of the patient of the pain following stool.

"The treatment consists in the divulsion of the sphincters and the usual stimulating after-treatment. The sentinel pile should be removed at the time of divulsion. Division of the external sphincter is not advised, for frequently it does not unite and eventually atrophies. Fistulæ, abscesses and fecal impaction are mentioned as frequent complications of fissure and call for appropriate treatment."

LOCAL VS. GENERAL ANESTHESIA IN RECTAL SURGERY.

By Dr. G. B. Evans, Dayton, Ohio, who stated that "Pain naturally is the common curse and dread, though relatively essential to the human family.

"The law of self-preservation, when an individual is threatened with pain is at once a law of resistance, manifest by intense expectancy and defiant attitude.

The shock incident to the terror of pain is incomparable to that which is likely to follow an abbreviated use of a general anesthetic. In consideration of the evolutionary plane occupied by the average American of today and the more remote period of his removal from the gorilla peripheral sensibility of the jungle, we are forced to conclude that he is more sensitive, and in need of greater consideration for the relief of pain. Because an operation can be done painlessly, it does not follow that there will not be subsequent suffering, and some, and perhaps severe shock.

"But in this nerve block period of Creile and Pennington, and the Gant period of dermal and sub-dermal distention we are told there is scarcely any use any more for a general anesthetic. Do we not believe as proctologists that in our operative field, sensibility is most difficult to abolish, and would it not naturally appear that more narcosis is necessary in this kind of surgical work and as a consequence more shock? Again, would it not be possible

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by the combined use of general and local anesthesia less shock would ensue, and more operations could be made with success. I believe that by using the local anesthetic preceding the general anesthesia we lessen the amount of the general anesthetic appreciably, diminish the dread and fear, and consequently diminish shock and danger thereby. Therefore, the combined method of narcosis, less anesthetic, suspending shock incident to conscious dread, as well as anesthetic shock, rendering more complete operative area, consequently more satisfactory work. It is simple to operate upon prolapsing piles, but not so simple to operate upon piles above the sphincters yet demanding operative interference.

"The injections of sterile solutions disturbs the parts anatomically. The frequent punctures through the tissues invite infection, and infection trouble. You can never measure the nerve and seldom the surgical will of your patient. Its chief advantage is that occasionally you are able to do work in your office and even then unsatisfactorily.

"I fail to see the advantage of operation under local anesthesia in your office and follow your patient home and give hypodermic of morphia over the usual custom of operating at home in the first place.

"An operation for hemorrhoids is a matter of some seriousness —often attended by some shock—often bloody, and the greatest caution should be observed that asepsis be obtained.

"I do not think it best for our patients that general practitioners should be taught that aseptic precautions at the time of operation and rest at home for a few days, is unnecessary. Do we not magnify the applicability of local anesthesia, will not accidents occur, are we not sacrificing perfect scientific work, are we not belittling our chosen work—a class of operations that are important and not free from danger?"

THE SIGMOIDAL FACTOR IN CONSTIPATION.

By Dr. E. A. Hamilton, Columbus, Ohio, who said: "In a certain percent of intractable cases of constipation, organic change in the wall of the sigmoid is the controlling factor. This change is entirely independent of any disturbance which may occur on

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the outer surface of the viscus; e. m., malposition and pathologic flexure due to adhesions. The change in the gut occurs in the sub-mucous and muscular coats and consists of a round cell infiltration of these coats which subsequently contracts, thereby to a greater or less degree narrowing the lumen of the bowel. The round cells change into spindle cells subsequently undergoing a metamorphosis into true connective tissue. The contraction of this connective tissue so narrows the caliber of the sigmoid that constipation of an obstinate type must result. This change is not always limited to the sigmoid, it frequently involves the descending colon as well; in addition to the contraction of the gut it loses also its resilience, which further adds to the difficulty of the passage of fæcal debris. The etiologic factor is the absorption of bacteria and toxic products from the sigmoidal contents. The mesentery is also involved, and is thickened and shortened.

The whole process is chronic, several years being required to bring on the condition. Surgery offers the only relief in an anastomosis which must be effected by any suitable surgical procedure between the unaffected position of the intestinal tract above and below the lesion.

A REPORT OF TWO CASES OF SIGMOIDOPEXY.

By Dr. S. T. Earle, Baltimore, Md., who said: "That in one of the cases there was the third degree of prolapse of the rectum, the invagination of the upper part into the lower portion of the rectum: in the other case there was a very acute flexure of the sigmoid upon the rectum, both of the conditions, as is well known, are frequently due to an abnormally long meso-sigmoid. The symptoms in each case were obstinate and persistent constipation, frequent bearing down pains in the lower pelvis, a sense of weight and especially a feeling of unrelief for some hours following a stool, or an attempt at the same; associated with these local symptoms were darting pains in various parts of the body, nausea, anorexia, frequent headaches and the various neurotic symptoms that go to make up a typical case of neurasthenia. The case of invagination was diagnosed positively by a digital examination while straining at stool, the sulcus being distinctly felt with the finger; the flexure being so acute that it was only possible to

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enter the sigmoid with the proctoscope by getting the end of the latter around the flexure, and pulling it aside. The flexure was so acute that it obliterated the lumen of the bowel at this point. The technique of the operation is such as is given in Tuttle's & Gant's works on 'Diseases of the Rectum and Anus.' I met with no special difficulty in performing the operations. The meso-sigmoid was very long in both. I was particular in pulling off the abdominal peritoneum where the sigmoid was to be held in apposition and also in attaching the sigmoid to the transversalis fascia. Both cases made good recoveries, except that one was retarded by a stitch abscess. The results in both cases were most satisfactory and pronounced, with almost immediate relief of the persistent and obstinate constipation, with the gradual disappearance of the neurotic symptoms. Dr. Gant has recently reported a number of sigmoidopexies and colpexies with most satisfactory results.

"Dr. Clark, in a paper read before the Medical and Gynecological Sections of the Medical and Chirurgical Faculty of Maryland, on February 15, 1907, called attention to the frequent associations of gastroptosis, floating kidney and enteroptosis in the same individual."

FECAL IMPACTION.

Dr. Lewis H. Adler, Jr., of Philadelphia, Pa., in a paper, entitled "Fecal Impaction," called attention to the result of obstipation causing an accumulation of feces in the cæcum or in any part of the colon; but the term impaction, the subject of the paper, should be usually employed when such an accumulation occurs in the pouch or ampulla of the rectum, or in the sigmoid flexure.

Attention was called to the difference between an ordinary persistent constipation and an impaction, as the latter may follow from a single attack of constipation; whereas, obstinate constipation may never, or only after a long period cause impaction. The symptoms of the two conditions are also very different, as an impaction is usually marked by a diarrhœa, whereas chronic constipation is associated with costiveness. After calling attention to the various causes of the malady under consideration, and the

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symptoms of the same, the treatment was detailed as consisting primarily, in the removal of the mass, and, secondarily in the relief of the inflammation of the mucous membrane occasioned by the irritating presence of the fecal matter as well as the removal of all causes which contribute to the constipated habit, which is undoubtedly the prime factor in most cases in producing an impaction.

The easiest manner of breaking up the fecal mass is to put the patient under an anæsthetic and then to forcibly divulse the sphincters, after which the mass may be disintegrated by means of the finger, a lithotomy scoop or an old fashioned iron spoon. In women considerable assistance may be rendered by passing a couple of fingers into the vagina and by this means steadying the mass so that it may be the more readily broken.

In some instances the writer was able to break up an impaction without resorting to anæsthesia, simply by using the finger and sometimes by the additional use of a bivalve speculum and a rectal scoop or spoon.

Previous to resorting to instrumental aid in the removal of the impaction, the fecal mass may be softened and its passage facilitated by the use of enemas, especially is this so in cases in which the sigmoid is the part affected, in which situation material assistance cannot be gained by the employment of instruments. For the purpose of administering the injection a douche-bag holding several quarts is to be preferred. The injection substance should be composed of soap and water, to which I have found the addition of glycerine of considerable benefit, a dessert-spoonful to a quart. When the impaction is in the sigmoid, the injection should be given through a Wales bougie,—preferably the one modified by Dr. Dwight H. Murray, of Syracuse, New York, which is stiffer than the ordinary article sold; which latter is frequently useless for the purpose intended, as it readily doubles on itself, and a high injection is rendered impossible by its use. When this method is employed the patient should be placed in the knee-chest posture.

A word of caution should be given here as to the danger surrounding the unguarded use of drastic purgative drugs in cases

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of impaction. By their employment peristalsis is increased and the fecal mass softened, but the bowel in its inflamed and distended condition may be thereby the more easily ruptured, and, if in addition, a stricture is present, the caliber of the gut may be entirely occluded by forcing into it the hard fecal mass with the attendant symptoms and consequences of total obstruction of the intestines. So much for the treatment of the actual impaction.

PRURITUS ANI—IS IT A DISEASE PER SE OR MERELY A SYMPTOM?

Dr. Louis J. Krouse, Cincinnati, Ohio, who quoted from the works of Bodenhamer, Agnew, Wright, Ball, Crepps, Gant, Matthews, Tuttle and others, their opinions regarding the etiology of this disease, and then stated "Pruritus Ani essentials is a disease which is due, not to a local, but to a constitutional cause, and is due to some trophic changes in the nerves supplying the parts." He further stated that the changes occurring in the skin of the anus and surrounding parts, namely, the hypertrophy, the loss of pliability, and the absence of pigment, can only be explained on the faulty nervous supply of the parts. He showed that an increase of pigment ought to accompany severe itching, and not a total disappearance, and finishes his article by saying that "The absorption of the normal coloring matter of the affected area does occur, notwithstanding that the epidermis was not destroyed, and said, "A similar process of absorption takes place in leucoderma.

"All authorities acknowledge that the cause of the latter disease is to be found in the nervous system," and concluded with the statement that "Pruritus Ani, at least in such cases, is a disease per se, and not a symptom."

Dr. Dwight H. Murray, of Syracuse, New York, presented a new Hemorrhoidal Clamp, which had the following qualities in combination, that make a first-class instrument, viz.: Scissors-shaped; parallel jaws; can be closed and released instantly with out the use of a thumb-screw; thereby saving much time while operating.

The Goodell dilator reversed is used as the ground principle for the lock.

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Dr. Dwight H. Murray, of Syracuse, New York, reported the case of a man 48 years' old who had been troubled with sciatica in the right leg for two years, and had also been a sufferer from hemorrhoids for ten years, having frequent profuse hemorrhages therefrom.

The hemorrhoids had not been treated. The sciatic nerve had been stretched and treated by various methods by a physician at his home town, included in which was the following completed in three sittings two (2) days apart.

At the first sitting, six hypodermic injections 1-150 grain of atrophine each were given into the sheath of the sciatic nerve. At the second sitting, seven injections of the same amount, and at the third sitting, eight injections were given as before, and one extra into the nerve before it leaves the pelvis. The patient was unconscious for fourteen hours after the last sitting, very little improvement resulted.

In November, 1906, the author was first consulted, and on December 12, 1906, operated on him for internal hemorrhoids. He made the usual recovery up to the ninth day, when there was a sudden profuse secondary hemorrhage. The patient was almost ex-sanguinated before the author arrived.

He immediately examined, found the superior hemorrhoidal artery was throwing a full-sized stream; this was secured; the patient stimulated, and made an uneventful, but slow recovery. The patient has had no sciatic pain since the operation.

Dr. Murray concluded that inasmuch as sciatica is often symptomatic, that no such severe treatment is justified until all possible reflex causes are first removed.

The cause of the hemorrhage was probably due to the thrombus or eschar at the end of the vessel being thrown off before thorough healing had taken place, and was influenced largely by his general anemic condition before operation.

THE TREATMENT OF ISCHIO-RECTAL AND PELVI-RECTAL ABSCESSES.

By Dr. I. Chittenden Hill, of Boston, Mass., who said: "That he employed general anæsthesia produced with ethyl chloride for

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the ischio-rectal abscess, and ether anæsthesia for the pelvis-rectal abscess.

His experience with infiltration anæsthesia has been unsatisfactory. He emphasized the importance of an early incision for peri-rectal abscesses, claiming that when acute symptoms have existed for a day or two, with pain and tenderness, even before there is much edema or discoloration of the skin, long before fluctuation can be detected, an incision may prevent abscess formation by allowing the escape of blood or serous exudate from the engorged blood vessels.

He advised a T incision and breaking up the existing septa with the finger, after which the sphincters are divulsed. He believed squeezing, scraping or disinfecting an acute abscess to be a great mistake, as it only serves to destroy the new granulation tissue and to spread the infecting bacteria. For the deeper ischio-rectal and in all pelvic-rectal abscesses he recommends rubber drainage tubes, discarding their use as quickly as possible in the after-treatment.

"He believed that the great majority of pelvic-rectal abscesses should be reached by perineal dissection."

CRYPTITIS.

By J. Coles Brick, Philadelphia, Pa., who said: "The anal valves and crypts, first pointed out by Morgagni, and called after his name, are found as vestigial remains of the junction of the rectal mucous membrane with the skin. They vary in number and size, but are absent in the anterior and posterior commissures. They have no known functions, but are the cause of obscure symptoms, when diseased, and from the fact that the valve or covering part of the crypt may conceal the diseased area, repeated examination will fail to show the lesion, unless each crypt is probed, when tenderness or pain will be felt. A conical fenestrated speculum is the best to use, and when the diagnosis has been made, the valve should be removed and the crypt converted into a raw surface, so that healing will obliterate it."

Dr. A. B. Cooke read a paper on "Observations on Certain Points in the Anatomy and Physiology of the Rectum." He ex-

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pressed the view that the usual conception of the external sphincter muscle is erroneous,—that under normal conditions it is not in a state of tonic contraction, but on the other hand, is at rest and passive, the shape of the muscle and the arrangement of its fibres being such that the anal aperture is maintained in a state of passive closure. It is not conceivable that a *voluntary* muscle should require the constant action of nerve force to keep it in a state of rest. The only action of this muscle is to voluntarily oppose or terminate the act of defecation by tonic contraction.

With reference to the internal sphincter, the essayist observed that there is no occasion to credit this muscle with any special action in addition to that of the circular coat of the bowel, of which it is a part. By reason of its location and thickness, it probably exercises some passive sphincter control, but its chief action is undoubtedly that of a detrusor, serving to complete the expulsion of feces and keep the anal canal free of contents.

The levator ani muscles, acting together, constitute the sphincter of the proximal extremity of the anal canal. To understand this it is only necessary to remember (1) that the upper or pelvic surface of these muscles presents a deep, funnel-shaped concavity, the beginning of the anal canal being at the lowest point; (2) the strong bundles of fibers which unite immediately behind the rectum arise in front from the pubis and anterior portion of the fascial line and pass downward and backward in close relation with the lateral walls of the rectum, crossing it obliquely at the upper limit of the anal canal.

The well-known difficulty of voiding urine while a costive stool is being expelled, which is usually attributed to the action of the levatores ani, is due rather to the pressure of the fecal mass upon the prostatic and membranous portions of the urethra, since, at the time of defecation, these muscles, like the sphincters, must be in a state of relaxation.

The part played by the anal canal in defecation is purely passive, except at the completion of the act when the voluntary muscles which enclose it are strongly contracted, expelling any remnant of feces and bringing its walls again into their normal relation when at rest of close apposition.

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The essayist dissented from the commonly accepted teaching that there is an inhibitory center in the cord which presides over the action of the external sphincter and which is called into action at the time of defecation to inhibit its tonic.

The relaxation which occurs at such times seemed to him fully explained by the mechanical pressure of the descending mass upon a structure which only offers passive resistance unless contracted by voluntary effort, and which possesses sufficient resilience, independent of any nerve influence to regain its normal form and tone as soon as the pressure is removed."

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Extracts from Home and Foreign Journals.

SURGICAL

Sulphur Waters in the Treatment of Syphilis.

Y. Dardel of Aix-les-Baines, France, says that the treatment of syphilis by the use of sulphur waters does not pretend to cure alone, but forms a very valuable auxiliary treatment which may be combined with a course of mercurial treatment, and will help greatly in the absorption, action, and elimination of the drug. The cure is indicated at any period of the disease, since nutrition suffers at all stages. Patients suffering from arteriosclerosis, or liver trouble, and those that are highly nervous should not undergo an active sulphur cure. It is especially indicated in those that take mercury badly, or can tolerate but a small dose of it, and when in those in whom the therapeutic action of mercury is not easily obtained. Also in cases of great destruction of tissue, or severe infections in feeble and wornout patients. Again in lesions of the nervous system, ulcerative lesions that threaten great destruction to the organs affected, and other such lesions in which there is no time to lose. The treatment strengthens the patient and enables him to take more mercury and assimilate it better. The sulphur of the water forms alkaline sulphides. Some are oxidized to hyposulphites and sulphites, but the most of it forms hydrogen sulphide, which is eliminated by the lungs and skin. It has a general tonic and exciting action and liberates mercurial compounds stored up in the system. The author describes the use of sulphur waters externally and internally at Aix-les-Bains, where massage combined with douching is an important factor in the treatment. Marloiz water is also drunk.—*Medical Record*, July 20, 1907.

MEDICAL

Apomorphine in Acute Alcoholism.

Charles A. Rossenwasser, of Neward, N. J., speaks highly of the value of apomorphine as a sedative and hypnotic in cases of acute alcoholism. It occurs in two forms, the amorphous and

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the crystalline, of which the latter is preferable. The usual dosage is from 1-30 to 1-10 grain hypodermically. A very few minutes after administering an emetic dose by hypodermic injection, vomiting occurs, due to the action of the drug upon the vomiting center in the medulla. Just before vomiting the pulse is weakened and increased in frequency, and after vomiting ceases it becomes stronger and slower, often stronger and slower than it was before the injection was given. Vomiting is preceded by salivation and slight nausea. It may occur only once, or be repeated several times. Very soon after the vomiting subsides, a matter of a few minutes in most cases, the patient falls into an apparently natural sleep, and may sleep for from two to eight hours, awakening refreshed, sober, and rational in most cases. It is not necessary, however, to give the emetic dose in order to obtain the hypnotic effect, and in many cases 1-30 grain will induce sleep.—*Medical Record,* July 27, 1907.

The Preappendicitis State.

John G. Sheldon believes that his experience with cases of appendicitis shows that there is a state of ill health preceding every attack of appendicitis characterized by intermittent, diffuse, slight abdominal pain, constipation in three-fourths of the cases, noticeable abdominal distention in a few, and slight tenderness on deep pressure over the appendix. Eighteen having these symptoms developed an attack of appendicitic within three months to a year after their appearance. Appendicitis is, then, always a chronic disease with acute exacerbations of the symptoms.—*Medical Record.*

Early Diagnosis and Home Treatment of Pulmonary Tuberculosis.

Emmet Keating, of Chicago, refers to cases that are really incipient, giving no marked tuberculous symptoms and no physical signs. The facts elicited from physical examination of the chest should be regarded as only confirmatory of the diagnosis. Important factors are family history, occupation, spitting of small amounts of blood, chilly sensations, very slight fever, an indefinite

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history of night sweats, loss of weight, constipation, clammy hands, a red line on the gums and shallow breathing. Respiration may be slightly jerking, with harsh inspiration. The pulse is accelerated. As to the treatment the author does not favor the use of tuberculin. He recommends beginning treatment with six weeks' rest in bed, in the open air as far as possible. Three meals a day should be taken and milk and eggs used besides. The most useful drugs are arsenic and nux vomica. No cough mixtures should be used. The best sedative is milk and eggs taken before going to rest for the night. Morphine is the only remedy for profuse hemorrhage.—*Medical Record,* July 20, 1907.

SOME OBSERVATIONS ON THE TREATMENT OF GRAVES' DISEASE.

J. Arthur Booth says that recent clinical and experimental data show that overactivity of the thyroid gland accounts for the symptoms of Graves' disease. The prominent symptoms may any one of them be absent in many cases. The treatment depends on the amount of thyroid intoxication. In slight cases hygienic measures go far to obtain a cure. Prognosis depends on heredity, position of the patient as to possibility of best treatment, and early recognition of the disease. In many cases better results are obtained by operation than medication. Thyroidectomy is the operation of choice. Cytotoxic serum has given brilliant results in many cases recently. Death after operation is due to shock and general anesthesia, and local anesthesia is to be preferred. The author reports twenty-five cases treated by him.—*Medical Record.*

TWENTY-FIVE YEARS' EXPERIENCE IN THE TREATMENT OF MALIGNANT NEW GROWTHS WITH ESCHAROTICS.

Wallace E. Brown makes use of potassium hydrate and zinc chloride as escharotics, because they are hygroscopic, in treating malignant diseases of all tissues, except on mucous membranes. In the mouth and pharynx carbolic and chromic acids are substituted. The zinc and potassium are prepared separately with hydrastis, which keeps them moist, and produces a stable solution or paste that will keep for years. The entire growth and sur-

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face beyond it is spread with the potassium hydrate, graded in thickness according to the thickness of the growth. This remains on for from fifteen minutes to five hours. On its removal the tissues are reduced to a soft, gelatinous mass. There is almost no pain, soreness soon passes away, and there is no inflammation. The application should be surrounded by an absorbent material to prevent spreading of the escharotic. The following day the zinc chloride is applied in the same way, which hardens and contracts the eschar, causing some tension. Exfoliation leaves a clean, granulating surface, that it not sensitive. It is covered with a petroleum product of high melting point, then with absorbent wood wool, and dressed each day. The growth is entirely destroyed and the patient does not have to go to bed at all. In the mouth and on mucous membranes the carbolic acid is applied first, and the chromic acid over it immediately, keeping well within the carbolic acid area. Eight illustratives cases are described.—*Medical Record.*

Treatment of Subacute Alcoholic Hepatitis.

Dr. Fred C. Thum, formerly demonstrator of anatomy at the Kentucky University, Louisville, writes on "Subacute Alcoholic Hepatitis"—a form intermediate between the acute hepatitis from a single protracted spree and the chronic hepatitis from long years of alcoholic excess. Calomel, podophyllin, etc., are not of very great use. Strikingly effective are pills consisting of salicylic acid, acid sodium oleate, phenol-phthalein, and menthol (probilin). They increase biliary secretion and render the bile sterile, thus inhibiting the inflammation in the hepatic structures.—*Medical Progress*, February, 1907.

Autointoxication in its Medicolegal Aspects.

Heinrich Stern tells us that modern toxicology has begun to conceive conditions and diseases as expressions of autointoxication, but these have not yet been recognized by medical jurisprudence. The author limits himself to a consideration of the catabolic poisons. Among these he enumerates retention of carbon dioxide, acidosis, constitutional diseases such as rickets,

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scurvy and diabetes, excessive ovarian secretion, retention in the blood of normal products of disassimilation, epilepsy, and chronic renal disease. The author gives clinical examples of each of these forms of autointoxication in which states existed which which caused a mistaken diagnosis, or supposed crimes, which involved unfortunate medicolegal conditions. He concludes that certain pathological states, as well as certain forms of death demanding legal inquiry, are due to autotoxic processes of catabolic origin. That catabolic autotoxicoses offer many discrepant legal aspects, and that the time has arrived when the catobolic autotoxoses should obtain legal status and citizenship in our courts of justice.—*Medical Journal.*

Chronic Perforating Ulcer of the Bladder.

Henry E. Leake, of Dallas, Texas, describes a case of simple perforating ulcer of the bladder observed by him that was fatal. The location of such ulcers is generally near the neck of the bladder, but in this case autopsy showed it to be remote from the neck, being situated in the fundus. There were frequent and painful contractions of the bladder, and almost constant pain, and a vesico-vaginal fistula was made to relieve the bladder contractions. There was marked pelvic peritonitis, and the ulcer had perforated all the coats of the bladder. The primal cause of such ulcers is defective cell metabolism, the origin and nature of which we do not understand.—*Medical Record.*

Auto-Suggestion and Seasickness.

(*Influence de l'auto-suggestion sur le mal de mer.*—Zbinden, *Archiv. de Psychol.*, August, 1906.)

A friend of Dr. Zbinden, with no previous sea experience, engaged himself as ship's surgeon on a voyage from Hamburg to Chili. The ship was due to sail during the night, and at 2 o'clock the surgeon was awakened by noises as of a ship on its course, and was seized with severe vomiting. In reality the ship was still in port, and the noises were due to the loading up of cargo. Shame at his impressionability cured the surgeon of the tendency to nausea, and he made the voyage without mishap. Following out

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the hint Dr. Zbinden made observations on himself and his fellow passengers during a rough voyage of three days from Norway walking about, eating and smoking freely, and generally comporting himself like the old sea-dogs on board, he succeeded in being the only passenger unafflicted. Some experimental suggestions he made to fellow-passengers met with success. He remarks that the mere fact of seeing somebody sick may have on other people a suggestive influence analogous to that of a nervous tic, which may contaminate a whole form at school. To guide check experiments he sums up his attitude as follows:

1. Seasickness is in all probability a neurosis.

2. It can be provoked or inhibited by auto-suggestion.

3. The fact of distracting the patient's attention from his woes assists in the care as in other neuroses.—*Rev. of Neur. and*

OBSTETRICAL

Primary Dysmenorrhea.

Maude Glasgow, of New York, notes the presence in city-bred women of disturbance connected with menstruation, without any lesions of the genital organs, which she refers to the sedentary life they lead, without out-of-door air or proper exercise. Toxic substances absorbed into the circulation account for menstrual fever sometimes noted. The chief complaint is of headache, nervous symptoms, and pain before and accompanying the flow. The cause is lowered vitality, or deficient strength and tone of the uterus. Mental effort at school alone will not cause this condition, but combined with in-door life and lack of air and exercise, it will bring it about. Shop girls, with their constant confinement, either standing all day or sitting all the time, will also have these symptoms. Prophylaxis should begin in childhood. Rest in bed at the period is unnecessary, but unusual exertion should not be taken. Wet feet and skirts should be avoided. The bowels should be kept regular. In the intermenstrual period hot douches, exercise, nutritious food and tonics are advisable. Hydrastis and nux vomica render good service.—*Medical Record,* August 3, 1907.

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

AMERICAN PUBLIC HEALTH ASSOCIATION.

The next annual meeting of the American Public Health Association will be held in Atlantic City, N. J., September 30-October 4, 1907. This important body, composed of representative scientists, sanitarians, and medical men from the United States of America, the Dominion of Canada, the Republic of Mexico, and the Republic of Cuba, occupies a position wielding a powerful influence on the conservation of the public health and the promotion of sanitary methods. The Association was organized thirty-five years ago, and every year since then it has grown in importance and in well doing. Through its agitation, State and municipal boards of health were formed, methods for checking infectious diseases were improved and demandes for pure water supplies were formulated. Every year has shown the imprint of its good work for the public weal, and every year demonstrates marked advancement of the objects for which the Association was organized. It is international in scope and its transactions at this meeting will be watched with interest in all parts of the world. The selection of Atlantic City as the place of meeting is a happy one and insures a large attendance and a valuable meeting. At this meeting a section of Vital Statistics is to be organized, and it is proposed to organize a section of Municipal Health Officers, the immense importance of both of which additions is obvious at a glance. An interesting program of set papers and discussions has been prepared, which is sure to prove of the greatest practical value and interest to the world at large. The

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following topics have been selected by the Program Committee for discussion:

1. Milk.
2. Laboratory findings in diphtheria.
3. Immigration in its relation to public health.
4. What nuisances should be abated by the board of health.
5. Control of the so-called minor infectious diseases.
6. Vital statistics and the value thereof.
7. The construction and care of streets from a health standpoint.
8. Amendments to Constitution and By-laws.

OBITUARY.

Dr. James M. Safford.

Hundreds of physicians throughout the South and West will learn with deep regret of the death in Dallas, Texas, July 2, ult., of the well-known educator and distinguished chemist, Dr. James M. Safford, formerly Professor of Chemistry in the Medical Department of the University of Nashville, and of Vanderbilt University. He was for years connected also with the Academic department of Vanderbilt. His students will remember him as one of their favorite professors. Painstaking, accurate and earnest his work impressed all who heard him lecture as that of a master. Gentle in manners and amiable in his disposition, he endeared himself to all with whom he came in contact. His works upon geology have become classical and his name is an authority upon the subjects he taught. His was a beautiful life, useful, pre-eminently practical, full of enthusiastic work, and fittingly ended at the ripe old age of 86

NOTICE TO SUBSCRIBERS.

Many of our readers are in arrears for subscription. Is it asking too much of our friends to send in the amounts due for subscriptions so that we may realize that they are still to be considered subscribers to the Journal? The Journal needs money, and we would like to see something of the *quid pro quo* in the shape of remittances. We assure you that we will take the greatest pleasure in acknowledging without delay the receipt of all such.

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Reviews and Book Notices

A Manual of Surgery For Students and Physicians, by Francis T. Stewart, M.D., Professor of Surgery, Philadelphia Polyclinic; Associate in Surgery, Jefferson Medical College; Surgeon to the Germantown Hospital; Out-Patient Surgeon to the Pennsylvania Hospital. With 504 illustrations. Philadelphia, P. Blakiston's Son & Co., 1012 Walnut Street. 1907.

We are pleased with this work, which has been prepared especially for the student and for the busy practitioner. It is certainly a *multum in parvo* publication and covers thoroughly the entire field of operative surgery. It is exhaustive, concise, thoroughly illustrated, and up to date. We note, however, many old cuts and diagrams, such as are found in the oldest text-books on surgery, which, however, detracts very little, if any, from the value of the book. It is a most excellent manual, and will prove of service to both student and practitioner

Manual of Diseases of the Eys, by Charles H. May, Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, New York, 1890-1903; Ophthalmic Surgeon to the City Hospital, Randall's Island, New York; Consulting Ophthamologist to the French Hospital, to the Gouverneur Hospital, and to the Red Cross Hospital, New York; Adjunct Ophthalmic Surgeon to Mt. Sinai Hospital, New York, etc. Fifth edition revised, with 362 original illustrations; with 22 plates; with 63 colored figures. William Wood & Co., New York. MDCCCCVII.

The fifth edition of this popular manual completely revised and enlarged has been received. Such additions and alterations as have been rendered necessary by recent advances have been made, and the book has been brought fully abreast with the times. It is copiously illustrated throughout with a good many original drawings, and the directions for the technique in all manipulations and operations are unusually clear and easily understood.

Text-Book of Psychiatry. A Psychological Study of Insanity for Practitioners and Students, by Dr. E. Mendel, A. O., Professor in the University of Berlin. Authorized translation edited and enlarged by William C. Krauss, M.D., Buffalo, N. Y., President Board of Managers, Buffalo State Hospital for Insane; Medical Superintendent, Providence Retreat for Insane; Neurologist to Buffalo General, Erie County,

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German, Emergency Hospital, etc.; Member of the American Neurological Association. F. A. Davis Company, Publishers, Philadelphia. 1907.

The name of Professor Mendel as author of this work is ample guarantee of its high standing and great scientific value. It is aptly termed in the translator's preface, A Psychological Study of Insanity. To all interested in this study this small volume should be welcome, as it is a clear, lucid and intelligible exposition of a difficult subject. The work of translation has been well done, and the translator deserves the thanks of the profession for the presentation of the subject in a most attractive form.

Diseases of the Stomach, by Dr. I. Boas, Specialist in Gastro-Enteric Diseases in Berlin. The sole authorized English-American Edition, from the latest German edition by Albert Bernheim, M.D. (Freiburg, Germany), Philadelphia, assistant to the late Dr. D. D. Stewart at the Polyclinic Hospital and Post Graduate School, as Instructor in the Department of Diseases of the Stomach and Intestines; Privileged Physician to the Jewish Hospital of Philadelphia; Examining Physician to the Free Hospital for Poor Consumptives, Philadelphia—White Haven; Consulting Physician to the Nazerene Home for the Aged; Ex-President of the Northern Medical Association, of Philadelphia. Illustrated with five full-page plates and sixty-five engravings in the text. F. A. Davis Company, Publishers, Philadelphia. 1907.

The thanks of the English-speaking public are due the translator for this excellent translation of a celebrated treatise. Its popularity all over the world is attested by the fact of its having appeared in Russian, Italian and Spanish. It is pre-eminently a work of reference for the practical physician intending to furnish him with a reliable guide to the intricacies and difficulties of a most important branch of every-day medicine. The author has endeavored to make his book a working manual, and to our way of thinking he has certainly succeeded in a remarkably successful manner. We feel sure that the reader will experience a sense of satisfaction in studying this treatise that does not follow all modern publications. We take great pleasure in recommending the work as one of the most complete and up to date books upon this subject that has recently been presented to the profession.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

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Original Communications

*Post-Typhoid Bone Lesions.

BY W. A. BRYAN, A.M., M.D., NASHVILLE, TENN.
(Adjunct Professor of Surgery in the Medical Department of Vanderbilt University.)

Any of the inflammatory bone changes may be produced by typhoid bacilli or by other micro-organisms building on a field already ravaged by typhoid bacilli; so that we may have periostitis, osteo-periostitis, ostitis, osteomyelitis, caries or necrosis; in a word, to repeat, any inflammatory bone lesion may accompany or be consequent upon typhoid fever. These changes may be acute or chronic, narrow or wide in their scope, single or multiple. The rule is that they are single, very limited in extent, chronic. They may involve either superficial or deep bone structures, with a distinct predilection for the former; probably these are more exposed to trauma, which here, as in similar lesions from different causes, serves as a predisposing factor in a large percentage of cases, although it cannot be elicited or even suspected in all.

The period elapsing between the initial symptoms of typhoid fever and the earliest manifestation of a resulting bone infection

*Read before the Nashville Academy of Medicine.

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varies widely. Frequently it is claimed that bone infections manifest themselves during the third week of the fever or during convalescence. This I have never seen. When they occur at this time they are frequently acute, and either run and finish their course as acute, or later assume the chronic type. But that typhoid germs may lie latent for indefinite periods and then kindle a distressing and dangerous pathology, there can be no doubt. Many cases are reported in which the intervening period has extended to several years, one, that of Sultan, going as long as six years from the attack of fever before giving rise to trouble. This could easily be doubted, were it not possible to show the typhoid bacilli in the pus, either in pure culture or mixed with pyogenic cocci. Yet it is in keeping with the well-known action of tubercle bacilli under similar circumstances, e. g., in Paget's abscess. The cases appended below are illustrations of this fact, as will be seen.

As to the pathological changes occurring I know nothing peculiar; they are the same practically as are seen in any such lesion from other infections. The incipient activity is shown either immediately underneath the periosteum or in the medulla, which is a favorite harbinger for these bacilli.

Cultures from post-typhoid bone lesions show either pure culture of the typhoid organisms or one in which is intermingled some pyogenic germ, usually cocci, unless the lesions following the typhoid are tubercular. That typhoid bacilli are capable of producing pus in pure culture has been demonstrated repeatedly; and that they may have been present in a bone lesion, and after secondary infection should disappear, while highly improbable, is still not impossible. After years of procrastination and palliative treatment typhoid bacilli are still found present and active, a factor that should be taken more into consideration. As a source of contamination of water and food, and of direct infection of attendants who may have to make dressings. Always in a case of chronic bone disease that discharges, the attendants should be cautioned to sterilize their hands and destroy cast-off dressings, for if there is no history of typhoid, it is in all probability worse, namely, tubercular; still, these patients are sent

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home at times by their physicians with never a word of instruction, when, if it were a case of phthisis or of typhoid fever we would enter into a long harangue about the importance of every precaution. What's the difference? Personally, I had as soon get fever by imbibing germs passed *per vias naturales* as those coming from a foul sinus. The fact that pyogenic organisms accompanying them does not reduce their virulence.

What bones are most frequently attacked? I have already stated that the superficial more frequently than the deep, and gave as a factor determining this difference exposure to trauma. Warren & Gould, in the International Text-Book, give the tibia as the most frequent site of typhoid bone infection; Brewer gives them in the order of "tibia, ribs, ulna, and the small bones of the hands and feet;" Rose & Carless place tibia and ribs first; Anders gives precedence to the tibia and reports a case occurring under his own service of infection of the os calcis; Abbe speaks of marked predilection for the tibia; my own cases were ribs in three, acromion one, os pubis one, external malleolus one. It would seem there is nothing unusual about the preponderance of tibial involvement, for Von Bergman teaches that the tibia is affected in acute octeomyelitis from all causes, "either alone or simultaneously with other long bones," more frequently than any other long bone, and quotes Von Bruns, giving the percentage of tibial involvement as 42%, while the fibula is attacked in only 3% of the cases. Hence typhoid involvement of the tibia is following the statistics of osteomyelitis generally, the cause being probably the external exposure of the shin to every obstacle that comes in front of a walking individual.

The symptoms of these post-typhoid bone lesions do not differ materially from the ordinary types, the pain, the fever, the local signs of inflammation generally and the course of the disease are nothing unusual. A point to be remembered is that the pain comes frequently very circumscribed in area, so that the patient will place his finger upon a spot and tell you the pain is confined to that point. This is often true when the pain is intolerably intense, and has served me well in one instance where the sinus seemed lost in an abscess cavity and offered no clue to further

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extension of my incision. Although the abscess cavity covered a large surface over the ribs, I sought the site of the original pain as the probable point of necrosis and found it just there. When an abscess forms thus over the chest from osteomyelitis of the ribs it is a remarkable fact that rupture of that abscess is always external and never into the pleura. After pus forms and rupture occurs or incision is made, then, as usually, a sinus remains, and the content of its discharge depends on the infection and the underlying pathology. Of the three rib cases reported below, two were on the right thorax, over the liver, and both of them came to me with a diagnosis of abscess of the liver, although none of the signs of hepatic involvement were present, and no suspicious history had been given. The other one escaped, being on the left chest. Post-typhoid bone lesions have a habit of improving apparently for a time and then relapsing to their former state, or a worse.

Treatment consists in thoroughly removing the diseased areas of bone, and such other means as are at our command for the cure of osteomyelitis.

Below are the reports of six cases I have treated during the past three years:

Case 1. Mr. Y., age 53; had been healthy until he developed typhoid fever in 1903. Some three months after convalescence he noticed a tender, painful spot at the left seventh costo-chondral junction. An abscess developed and was opened by a local physician. This never healed, although at times it became very small and gave the impression that it would soon be well, only to grow worse again. There was a slight discharge of pus when I saw him in April, 1904; the patient thought about a tablespoonful of pus escaped in 24 hours. Probing revealed exposed bone rough and ragged. On operation it was found that the rib was more extensively involved than was apparent before the incision, so that nearly the whole of it was excised. Drainage was made at either end of the wound. Complete recovery in four weeks.

Case 2. Miss S., age 21; was sent to me September 12, 1906, for examination as to the cause of a persistent sinus situated on the inner surface of the right thigh about 2½ inches below the

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crotch. An abscess had formed and was "lanced." Evidently this had been chronic in its nature, as she had allowed it to continue several weeks before consulting her physician. She had had the diseases of childhood, and had an attack of typhoid fever fifteen months prior to my examination. Introduction of a flexible probe showed diseased bone. She was anesthetized and the sinus slit up and a lot of diseased bone removed from the os pubis. Healing was prompt, but a sinus and discharge remained. On December 7, 1906, a second operation was performed, when the sinus was opened and a large transverse incision made across the symphisis pubis and almost all of the right body of the os pubis and much of the left were found diseased, and removed, until I dared go no further. This time there remained two sinuses, one of which healed about a month ago under repeated injection of a pepsin solution, and the other is improving slowly, but surely.

Case 3. Mrs. B., age 28; a strong, healthy woman, with no history of illness bearing on her present condition, except typhoid fever about a year prior to her visit to me in December, 1906. She was married and had two children, both of whom were living and well. She did not know exactly when her present trouble began, as it had caused her but little inconvenience until an abscess formed and ruptured on the anterior surface of the right arm about 1½ inches from the axilla. There was a healing sinus situated beneath the outer end of the clavicle. Probing revealed nothing. Under ether anesthesia the sinus was cut on a grooved director entered as far as possible, i. e., to a point where the sinus curved. Then the sinus was followed until it led, all the time under the deltoid muscle, to the acromion process, which was diseased, soft, carious, well back on to the spine of the scapula. Complete removal and drainage was followed by prompt healing.

Case 4. Mr. L., a farmer, age 45; healthy all his life and able to do the hardest manual labor; had typhoid fever two years before coming to Nashville in April, 1907. He didn't know just when the bone began to trouble him. First, an abscess formed

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and was opened, with a diagnosis of "abscess of the liver burrowing outwards;" he was very much emaciated and exceedingly weak, yet able to walk about. Under ether the sixth rib was resected, and the wound, which was extensive, closed with drainage. A portion of the rib above and the one below was involved and removed. The patient did well for ten days when he developed septicemia and died near the end of the fourth week.

Case 5: Rose W., a child 12 years old; an inmate of a local orphanage, had typhoid fever about two and one-half years ago, and subsequently developed a swelling over the external malleolus of her left foot. This became very swollen and was opened by her physicians, who had treated it before opening, by immobilization with plaster of paris dressing, to no avail. After opening it, the sinus refused to heal, and her physician diagnosed tuberculosis of the tarsus, and advised amputation as the sole remedy. She came under me last May. The joints of the foot were not involved, and the roughness was, as far as I could determine, confined to the malleolus. Injections of hydrochloric acid and pepsin soon changed the discharge from a purulent to a serous one, and then the foot was encased in plaster of paris with a window over the sinus for dressings. The opening gradually diminished, the discharge decreased. Two months ago, almost, the foot was encased in a new plaster dressing, with no window, and this was removed last week, when the sinus was found entirely healed, the swelling all gone and the foot normal. This patient was in apparently good health, but she was put on iodine and Russell's emulsion of fats internally lest there might be tubercular infection. If they do good in that, why should they not be used in other chronic bone diseases? She is now rosy and fat and I think the foot is worth to the child the pains the surgeon has taken.

Case 6. Mr. P., age 50; had been healthy until last December, when he developed typhoid fever, which kept him in bed until

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the following March. Just as he was recovering from this and beginning to walk about, he was seized with a severe pain over the cartilage of the seventh rib. He could cover the painful spot with the tip of his finger. There was pain in the right shoulder. Nothing relieved these, but active anodynes. Shortly he noted a slight swelling over the rib at the site of the pain. This gradually increased and extended downward and to the right. It was diagnosed abscess of the liver, tentatively. When I saw him in June of this year, the swelling was some six inches long by three inches wide. The swelling lay with its long diameter parallel to the ribs. The pain was unabated. My diagnosis was necrosis of the rib, and immediate operation was advised and accepted. On incising the swelling a large amount of pus escaped and a smooth cavity was found superficial to the ribs and covering three of them. There was no evidence of a sinus leading from a rib to the abscess as I had expected to find, and my diagnosis looked like a joke. Recalling the site of the pain I searched as nearly as possible at its location and seemed to discover a slightly darkened area, which was incised and showed that an inch or more of the cartilage had been destroyed. There was a slight border of the cartilage of the eighth rib diseased. The bad cartilage was removed and the wound closed with drainage. This gentleman reported by letter ten days ago that he is doing well, but there remains a sinus and now and then a twinge of pain in the scar, and sometimes an aching of his shoulder.

These cases are offered for what they are worth. It would be better if there had been in every instance a bacteriological examination, for that would eliminate all errors; but I think I have fairly well excluded tuberculosis, unless it be in cases 2 and 3, and the fact that in each instance typhoid fever had been present within two years favors the correctness of my diagnosis. In no case was there forthcoming evidence of trauma, yet that by no means precludes it. One would scarcely expect to find that number of cases without at least one involving the tibia.

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OBSTETRICS AND GYNECOLOGY.

BY E. S. M'KEE, M. D., CINCINNATI.
(Lecturer on Clinical Gynecology, Medical College of Ohio—University of Cincinnati.)

MENSTRUAL FEVER AND MENSTRUAL SEPSIS.

Riebold (*Deutsche Med. Woch.*) observed 2,000 patients within the last two years as to the temperature at the menstrual period. He concludes that in many cases there is a rise of temperature during menstruation that cannot be accounted for as from any other cause. The fever occurs generally on the third or fourth day, though it may come earlier or even after the flow has ceased. The fever and the leukocytosis attending menstruation are due to the absorption by the uterus of toxic or infective materials. During the menstrual period the contained blood and mucus in the uterine cavity forms a very good culture-medium, and at this time the normal protective of the vaginal mucus is absent. The author believes that the menstrual period is of great importance in the pathogenesis of febrile disorders. A toxin similar to that producing the fever may cause many skin and nervous affections which occur during menstruation, such as erythema, urticaria, herpes zoster and neuralgias. They also cause rheumatism in the form of true polyarthritis and heart rheumatism due to infection arising in the genital tract.

HYSTERIC APHASIA, AGRAPHIA AND ALEXIA AT THE APPEARANCE OF FIRST MENSTRUATION.

Vitek (*Zentralbl. f. Innere Med.*) reports the case of a very irritable girl, fourteen years old, who became so frightened at the sight of the first menstrual blood that she fainted. After consciousness had returned she was unable to speak, although she could see and recognize things. After a few days, when the menstrual discharge disappeared, speech gradually returned. At that time patient observes that she can neither read aloud nor write. The author bases his diagnosis of hysteria upon the following symptoms: Sudden appearance of the pathologic condition subsequent to a psychic trauma, the presence of such hysteric

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stigmata as globus and tenderness to pressure of ovarian region, no lesion of the heart, absence of any paresis in either cheeks or extremities and the prompt relief afforded by suggestive therapy. Vitek explains the condition as a spasm of cerebral vessels, probably of those on the brain surface. An exaggerated vaso-motor irritability, especially in neuropatic individuals, is a rather common occurrence at the time of puberty.

SORE NIPPLE.

Some practicians advocate the bathing of the nipples during the last months of pregnancy with alcohol and boric acid, while others are of the opinion that these hardening preparations simply make the nipple more prone to crack during lactation; they advocate the application of ointments in place of alcoholic lotions. The present-day treatment of sore nipples is quite variable and a different method; every case is a law unto itself. We all remember the cardinal principles to be observed—the care of the breasts before and after nursing; the care of the baby's mouth and the much-needed rest. It is undoubtedly true that the breast pump is being condemned by many practitioners; the massaging of the breast in case of sore nipples yields far better results than the evacuation of the breast by means of the pump. And yet we find practitioners, especially in the country (and, I am sorry to say, in the city as well) who persist in advising the application of the breast pump.—Courier of Medicine.

CAUSES OF STERILITY.

G. G. Ward (*American Journal of Obstetrics,* August, 1906) has drawn the following conclusions:

1. As conception is dependent upon healthy spermatozoa, normal ova, the union of the same, and the proper implantation of the fertilized egg, so sterility is most frequently dependent upon acquired lesions and congenital defects which cause sterility by interference with these essentials.

2. Many causes of acquired sterility are due to lesions which cause such changes in tubes and ovaries as to prevent the union of spermatozoa and ova.

3. Gonorrhea is the most frequent cause of such lesions.

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4. Acquired sterility in many cases is due to endometritis, which causes such changes in the endometrium as to prevent the proper implantation of the impregnated ovum.

5. Sterility associated with flexions, displacements, subinvolution, fibroids and other neoplasms, is caused by the accompanying chronic endometritis, which prevents proper implantation.

6. A cause of unhealthy endometrium and of tubal disease which may prevent union of the male and female elements is the chronic inflammation and congestion of the uterus and adnexa incident to subinvolution and sepsis.

7. Gonorrhea not only causes sterility in women in 70 per cent. of cases, but is also the cause of sterility in the male.

8. In two-thirds of all cases of gonorrhea in women, the woman has been infected by the man.

REPORT OF A CASE OF ENCEPHALO-CYSTO-MENINGOCELE OPERATION.

Fred. J. Taussig (*Med. Fortnightly*) discovered a meningocele protruding through an opening in the cranium hardly larger than the end of one's thumb, as the head was bulging the perineum. Six hours after delivery a beginning necrosis was noticed at the top of the mass and an operation was determined on. This meningeal sac was cut away and within this sac was found a small piece of brain tissue which was ligated and cut away. The skin was closed with interrupted silk-worm-gut. The child passed a good night, and on the following day there was a possibility of its surviving.

Notes of a case of ovarian cystoma in which thyroid tissue occurred:

Dr. J. H. Swanton (*Med. Press*) reports a case is more interesting from a pathological rather than a clinical standpoint, as only nine cases of this variety of tumor have been described. The author is inclined to submit his case as one of teratoma.

In general appearance the tumor was tri-lobed, the lobes consisting of three large cysts, the largest measuring three inches in both its diameters and presented extremely thin walls. By transmitted light yellow tissue was seen in patches on the inner surface of the wall. At the confluence of the three cysts there

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was found a solid mass of tissue, which in section presented a multilocular cystic appearance, the loculi being filled with solid material. The tissue was found to have a typhoid structure consisting of loculi lined by low-lying cubical epithelium and containing colloid material in which were ghost-cells and spaces occupied originally by fat crystals.

The microscopical section shows a smooth outer capsule undergoing hyaline degeneration; inside the ovarian stroma is somewhat broken up with clear spaces between as if edematous. Numerous groups of deeply stained nuclei are seen irregularly arranged, some of the cysts being more surrounded than others. Then comes a reticulated structure, and beyond this several cysts with low cubical epithelium. The central portion is stained with eosin, and in some cysts is separated from the wall. In the central portion may be seen empty spaces, some oval, while others are irregular.

When a treatment of thyroid tissue exists in the ovary at the time of diminishing activity at the thyroid gland, a compensating hyperplasia may take place, which subsequently develops into either an innocent or malignant growth.

PUERPERAL SEPSIS.

Dr. S. Marx (*Medical Record*) maintains that practically all cases of puerperal septic infection arise from ulcers in some part of the genital canal. He places these ulcers in two classes: (1) Desquamative; (2) exudative. When an ulcer is visible it should be cauterized with pure carbolic acid, and the action of this stopped in a minute or two by alcohol. This is repeated every twenty-four to thirty-six hours. When the ulcers are confined to the lower genital tract, the uterus is not to be invaded.

CANCER IN THE CERVICAL STUMP.

Andrew F. Currier (*New York Med. Journal*) believes that after hysterectomy the patient should be examined at periods of six months to ascertain if the cervix is involved by cancer. This is especially desirable for those whose tissues are in a bad condition of nutrition or who suffer from hereditary taint. Com-

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plete removal of the uterus offers greater security from cancer than does retention of the cervix.

NECROSIS OF UTERINE MYOMATA.

Rouville and Martin (*Arch. General. de Medecine*) says the causes of a necrobiosis of uterine myomata are either torsion of a pedicle or sepsis. It could be expected that subserous myomas are especially liable to necrosis from torsion, but this occurs more frequently in the submucous variety. The degree of torsion in the former varies, according to different writers, from three-fourths of a turn to two and one-half turns, which almost always occur in the direction of the moving hands of a clock. Often the uterus participates in the torsion. On rare occasions this twisting has resulted in a complete spontaneous separation of the uterine body from the cervix; not infrequently the fibroid in this manner becomes detached from the uterus. The gangrene resulting in subserous myomas from twisting of the pedicle is aseptic, as opposed to that occurring in the submucous variety. Interstitial tumors are less affected, but less rarely are exposed to a septic gangrene. Ergot and electrolysis play an important role in the necrosis of fibroids, and pregnancy certainly seems to predispose these tumors to a necrobiotic process.

Professional Confidences.

BY E. S. MC KEE, M.D., CINCINNATI.

The question of professional confidences, professional secrets, or privileged communications is ever an interesting one and decisions of interest are now and then handed down. One of remarkable rarity occurred recently in England. A chauffeur was taken ill, went to a public institution for treatment, and there came under the medical care of his employer, who was in service on the staff of the institution. The doctor found the patient suffering from aortic disease which rendered him a fit subject for sudden death at any time. The physician betrayed the pro-

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fessional secret to his business self and on the chauffeur's recovery told him of his condition, and said he did not wish to risk his neck with a man in his condition, gave him two weeks wages and discharged him. With the aid of an unoccupied attorney, the chauffeur brought into court the question whether the employer coming into possession of information in his professional capacity, might use this information to determine his actions in a business capacity to the detriment of the employe. Was it as alleged a shameful abuse of a privileged communication? Was it the duty of the employer as a physician to continue to ride with the chauffeur, keeping inviolate his professional secret, until the aortic lesion resulted in a broken neck for the medical man, at which time it would be perfectly proper for him to discharge the chauffeur for incapacity? The court, however, took a very common sense view of the subject and rendered a decision in favor of the medical man.

An interesting decision of fundamental importance was rendered recently in the high court of justice in Leipsic, Germany. A woman had contracted syphilis from a man and after his death sued to recover damages from his heirs. The medical attendant of the deceased was summoned to testify, but declined on the ground that the law imposes silence on medical men in regard to the ailments of their patients. The plaintiff's counsel made a vigorous plea that the law of secrecy was no longer binding after the patient's death. The court ruled that only the patient himself was competent to release his medical attendant from the obligation of secrecy and since he had not done so before death it was fair to presume that he did not wish to do so. Surely death should but render more sacred the confidence placed in the physician by his patient.

The following resolution was presented and passed at the Paris Academy of Medicine: "A radiograph is a document consisting of something taken directly from the patient, is something of the personality of the patient; and therefore the use of a radiograph comes under the law of professional secrecy in its strictest sense. Take for example a case of early phthisis, or one of syphilitic exostoses, examined by a man outside of the medical pro-

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fession who is not bound to professional secrecy. It is the sense of the Academy, as indeed it must be of the whole profession, that *X*-ray pictures should not be taken except by the medical profession." There is an effort being made to prevent the practice of radiotherapy in Paris by any but the medical profession.

The law on professional communications is that the doctor, lawyer, or minister cannot be compelled to testify in court, or elsewhere, what professional knowledge he has obtained about his patient, client, or parishioner, unless he or she wishes him to do so.

Following are some of the many puzzling cases which have come before the writer in his experience:

Case I.—A near neighbor, a delightful friend, a good patient, died while we were together one evening quite unexpectedly. He had been suffering from a slight ailment, and I was with him till he should go to sleep. When comparatively comfortable and in conversation he, without a moment's warning, dropped dead. His old mother, whose only child he was, gave way to the most uncontrollable grief. There was no one else to blame, so she blamed me and did it good and strong. Her brother, a physician, a good friend of mine, incensed at her persistent and prolonged abuse of me, told her that her darling boy had contracted syphilis thirty years ago which had caused his arteries to be friable, and was the cause of the cerebral hæmorrhage which had caused his death. This of course enraged her very much and she did not again visit her brother till he was on his death bed. I think the doctor did wrong. No amount of abuse of me should have led him to tell his sister that her idolized son had had the syphilis and thus pile sorrow upon sorrow.

Case II.—A young man came into my office one day and in a few brief words gave me to understand that he had infected his wife with a specific disease and he wished me to come and treat her. I went and found his statement correct, and conducted the case to recovery. Shortly afterwards they removed to St. Louis and, remarkable to relate, forgot to pay me. Later a still stranger thing happened. They each began to pay me in installments of five dollars each. They kept about neck and neck, and I kept

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still. When they had both paid in full I returned the wife's money to her and kept his. In due time the anxiety of both to pay the bill was explained by the filing of a plea for divorce on the part of the wife. I was summoned to give my deposition in the case. I was asked what the young man had said to me when he called me, and I declined to answer, claiming privileged communication. I was dismissed and called five times. The fifth time a constable was called and I was placed under arrest and was told that I would have to go to jail and remain there till I was ready to testify on that point. I advised them not to send me to jail, which counsel they seemed to think good, and said that if I would appear before the judge the next day I might go. I promised. At the appointed hour I appeared. The case was argued and taken under advisement. I was asked to reappear in a week, which I did. The judge was not ready with his decision and I was called the third time, and at the end of three weeks was ordered by the judge to testify on this point. The argument was that the wife was the patient, the husband was not. The wife, as the patient, wanted the testimony given, hence I was ordered to give it. Had the wife not wanted me to tell I would not have been allowed to tell. The husband had come to me as to a physician, talked to me as a physician, asked me to treat his wife, giving me such information, in confidence, as he thought I needed to best manage her case. Had I treated him I could not have been ordered to testify. Here lieth his error. The judge knows more about the law than I do and probably interpreted it correctly, but if such is the law it should be changed. I should not have been ordered to tell what that woman's husband told me in confidence as a physician.

Case III.—The husband of a young lady whom I had treated for various ailments when a young girl came to me for treatment of gonorrhœa. During the course of the treatment the wife became suspicious and approached me, wanting to know what was the matter with her husband. I replied that I would not betray secrets gained professionally from him any more than I would from her. She was no fool, however, and went to the

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public library, read up on the subject—a reprehensible privilege—and settled in her mind as positively as only a woman can that her husband had gonorrhœa. There was war for a time, then a short truce, then she came to me with the gonorrhœa. A divorce followed in due time. I was summoned in court but could not be made to tell on either because neither had been so foolish as not to employ me.

Case IV.—At the clinic of the Medical College of Ohio, during the summer there came to me a patient affected with a venereal disease. On the return of the students at the opening of the session she forbade me telling them what was the matter with her as she had a personal acquaintance with some of them. Had I really the right to tell them what was the disease affecting her or even to demonstrate it to them? The rights of the poor patient in the sight of the law are as those of the rich.

Case V.—A case of unusual interest was that of a beautiful girl who was brought to me by a relative on the last of January. The relative said she had not been well since Christmas, when she was on month's visit to a distant city. She was out of sorts, seemed grumpy, nervous, pains peculiarly placed, and no satisfactory symptoms. I prescribed and they left. A few weeks later she came to me without her relative and said she had not been unwell since Christmas. She consented to a vaginal examination with surprising readiness, and I told her I feared she was pregnant. She acknowledged the opportunity and said she would get rid of it. She kept her word, and about the time of one of George Washington's numerous birthdays she sent for me to attend her in a flooding spell. She disappeared from view for the present. In June she came to me a perfect wreck. Vaginal examination revealed the microscopic symptoms of a badly neglected gonorrhœa which was confirmed by microscopic examination. Seduced, impregnated, aborted, diseased, who but he who had brought this on her should marry her and take care of her the rest of her days? The poor girl was lean, sick, thin, and weak. The long neglected gonorrhœa had involved the vulva vagina, cervix, uterus, tubes, and ovaries. She dragged slowly through

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the summer, and in the fall began to regain some of her former good health and good looks, though the half of each seemed gone forever. The question ever present in my mind was, ought I to tell her what was the matter with her and raise trouble generally? Ought I to tell her her real condition? Ought I to tell her mother her condition? Ought I to tell her lover her condition? Her lover, though devoted, seemed not to be matrimonially inclined. Ought I to try to hasten the wedding and would I by such action do more harm than good? To tell our own secrets is folly, to tell those intrusted to us is treachery. We should always remain faithful to our trust, and a professional secret is the most sacred of trusts. We should lock up our patients' secrets in our memory, give them the key, and then forget.

The disturbing complications of the case are these: When she came to me first she had just been on a visit to a distant city where she had a lover. Her Cincinnati lover, more cupidus than avarus, had allowed the case to become chronic. The suspicion crossed my mind had she not conceived while away from Cincinnati, and was not her distant lover the father of her fœtus rather than her Cincinnati lover? What confirmed this suspicion was the fact that she would not allow me to mention in any way whatever to her Cincinnati lover the fact that she had been pregnant and had had a miscarriage. That he was the originator of her gonorrhœa I do not doubt, but that he was the father of her fœtus I do doubly doubt. I believe in truth that while she was away they were both untrue.

The lover lagged. Ought I to try to force the wedding or would I by so doing do more harm than good? I decided inaction to be the better part of valor, and let matters take their own course. The result was as good if not better than could have been expected. The placenta nuptials was passed about nine months after the placenta fœtalis had been passed. To state it plainly, they were legally married.

Verily, truth hath driven fiction into exile.

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Hay Fever.

BY E. S. MC KEE, M.D., CINCINNATI.

About the time that the hay is all carefully stored away in the mow out of the rain then we have to combat hay fever. The proper time to write on this subject would be after the close of the season, but hindsight is much better than foresight on this as well as many other questions. I think we made some distinct advance on this line last season, and to recall attention to the study of this trouble, to express the hope that we will make still greater advance this season, and possibly add my mite is the object of this paper.

AIR FILTRATION.

The filtration of the air which enters the nose is a matter of much importance. This is why the growth of hair is there and is why many ointments help simply by stopping the pollen which the air contains. Bits of cotton have been inserted in the nose with some benefit. Apparati have been used consisting of rings made of cork, hard rubber, or, best, of German silver. These rings have stretched over them thin linen or chiffon silk. They are placed within the nostril perhaps a half-inch up, so that all the inspired air must pass through them. Many patients obtain much relief by sleeping with a thin moistened handkerchief over the face.

HAY FEVER AMENABLE TO NO SPECIFIC TREATMENT.

H. Holbrook Curtis considers hay fever a disorder amenable to no treatment of a specific nature. About one-third of the cases of hyperesthetic rhinitis are from other causes and other pollens than the ragweed. About one-third of the cases supposed to be due to pollen reaction may be relieved by constitutional and surgical methods of treatment. Predisposition to attack in these cases being due to definite causes, would suggest the view that induced enervation of the sympathetic is an important factor in the etiology. Primary intoxications may take place from pollen toxines in cases where the sympathetic system is not previously

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enervated. These cases theoretically should react to antitoxine treatment. The concensus of opinion today is against pollantin, though the observers instructed personally by Prof. Dunbar endorse unqualifiedly the great benefit to be derived from the treatment. Medically, the supra-renal capsule products hold the first place in the treatment of hypertrophic rhinitis. The importance of constitutional treatment as an adjunct to any local application is of supreme importance. The best of all treatments yet found is the climatic, with primary attention to the nasal condition.

THE USE OF MORPHINE AND COCAINE IN HAY ASTHMA.

Though most of the text-books call attention to the great danger from the administration of morphine and cocaine in asthma, this fear is probably overdrawn. Most practitioners find that it is necessary to use one or both in severe cases before relief is obtained, and it is generally found that when the distress disappears the desire for these insidious remedies is also gone. If carefully watched and kept under the control of the physician these drugs are not very dangerous in this disease, and form a very necessary part of the treatment. Especially is this true of those cases where the attacks occur at rare intervals, that it is safe to use morphine and cocaine with caution. More care is necessary in those cases where the status asthmaticus is more or less constant. It is an important thing to know that quite small doses will furnish a remarkable amount of relief, and, in fact, less than the ordinary sized doses are required. When we note that the patient is demanding larger doses, then is the time to reduce, stop or switch the drug. To repeat: these two remedies are of much use in these conditions and are not as harmful to the patient as most of us believe in hay asthma.

THYMOL IODIDE IN HAY FEVER.

This has been found of much service. It is used on the theory that the point of departure of the reflex irritation which produces hay fever is situated in the mucous membrane of the antrum of Highmore. The thymol iodide should be insufflated through the orifice of the maxillary sinus situated in the middle meatus of

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the nasal chambers. It should be applied with a fine powder insufflator with a curved cannula. The relief is quite marked and of long duration, though in some it is necessary to repeat the application.

THE NERVOUS SYMPTOMS.

These are of great prominence in hay fever, and should be given due consideration. All hurry and worry should be avoided. The patient should live the simple life as to habits, diet and sleep. Rich foods are especially to be avoided. Dark glasses add to the tranquility of the eyes.

DUNBAR'S POLLANTIN.

This remedy, though not proving as beneficial as its advocates thought it would, yet it is distinctly palliative in 30 to 60 per cent. In about 30 per cent of cases both pollantin and suprarenalin fail to give any effect. The nose should be thoroughly cleansed with alkaline solutions. The application should be thoroughly made and the patient should lie down for ten or fifteen minutes after the application.

SUPRARENALIN.

This remedy is best given in tablets put up with a very small amount of milk sugar, each tablet containing from one-fortieth to one-tenth grain. This should be placed upon the tongue and allowed to melt there. It is not proper to swallow it as a pill. This can be repeated in the course of from ten minutes to two hours according to necessity. The need of repeating depends on whether the patient remains at home or goes out in the dust, bright sun, or in the country. It varies also in different individuals.

The following are some good formulæ:

Suprarenalin.....gr. 1-6 or 0.01
Adeps lannæ,
Adepis benzoati | aa.....dr. i or 4.00
Petrolati,

Mix well and dispense in tubes.

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Suprarenalin.....gr. 1-6 or 0.01
Adepis lunnæ.....dor. 1 or 4.00
Unguenti zinci oxidi.....drs. ii or 8.00
Ol. olivæ.....drs. iiss or 10.00
M. S.—Dispense in tubes and apply in the nasal passages.

Suprarenalin 0.01
Zinci stereat. comp. 1.00
Magnesiæ carbonatis 9.00
M. S.—Triturate well and use as a snuff.

Suprarenalin 0.01
Bismuth subnitratis 3.00
Zinci oxidii 3.00
Zinci stearatis 2.00
M. Triturate well and use as a snuff or in a powder blower.

A good spray formula:

Cocaine hyprochl. 1.00
Adrenalin (1: 1,000) 4.00
Normal salt sol. 60.00
M. S.—Use as a spray in the nose.

ATROPINE SULPHATE AND HYOSCINE HYDROBROMATE.

These remedies in very small doses are beneficial—for instance, given in doses of from 1,2,500 grain.

DURING THE ASTHMATIC PAROXYSM

give 1-10 grain tablet suprarenalin on the tongue and repeat in ten or twenty minutes if necessary. Suprarenalin or adrenalin solution 1: 1,000 may be applied to the nose by spray or on cotton. The quickest means of obtaining relief is to administer suprarenalin or adrenalin solution, 1: 1,000, hypodermically, in ten to twenty-minim doses.

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Is Conservative Treatment of the Ovaries Overdone?

BY E. S. MC KEE, M.D., CINCINNATI.

The above subject is under discussion in the *British Medical Journal,* and Professor Bovee, of Washington, is quoted rather incorrectly; at least a wrong impression is drawn from his words, which, correctly quoted, are as follows: "In the first place, through the very careful and prodigious work of C. P. Noble, and a few others, the fact is demonstrated that in 5 per cent of the consecutive cases of cancer of the uterus that come under operation and studied microscopically, malignant disease of the corporal mucosa of the tumor or of the cervix was present at the time of the operation or developed later in the stump." From this Bovee makes his third conclusion respecting conservative treatment of the appendages: "That as 5 per cent malignancy exists in the cases of malignancy brought to operation, and in 30 per cent marked complications of the appendages are present, leaving in the ovaries when the uterus or its body is removed, is hazardous to the future well-being of the patient.

PALLIATIVE TREATMENT OF INFECTIONS OF THE FALLOPIAN TUBES.

Thomas J. Watkins, in Bovee's "Practice of Gynecology," uses the term palliative because he considers that no known non-operative methods can cure salpingitis. If a cure follows treatment it is due almost entirely to the efforts of nature. Palliative treatment is of great importance, as it tends to lessen the suffering of the patient, especially in acute cases. In these acute cases the principal treatment consists of (1) Recumbent position; (2) ice-bag or hot water-bag over the lower part of the abdomen; (3) hot vaginal douches; (4) liquid diet; (5) saline cathartics, preferably per rectum; (6) opiates when necessary for severe pain. The recumbent position lessens the amount of pain and may lessen to some degree the extent of the infection. The ice-bag acts as a local anesthetic superficially and lessens the amount of fever, as cold to any part of the body. If ice is impractica-

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ble, dry heat may be used with the same results. Hot rectal douches would come in much closer proximity to the ovaries than hot vaginal douches, and hence do much more good. Liquids should be given in large quantities to stimulate the excretory organs. Saline cathartics are of use to prevent accumulation of feces and increase elimination. The following enema will also produce catharsis:

Magnesia sulphatis ----------30.00
Glycerinæ ----------60.00
Aquæ ----------90.00

M. S.—Use as an enema once or twice daily.

Opiates, preferably codeine, should be given if the pain is severe and interferes with sleep. In nearly all cases of acute salpingitis the above treatment is all that is required.

A discussion of the non-operative treatment of chronic salpingitis is of importance on account of the large number of cases and on account of the very extensive use of vaginal applications. He did not believe that they did much good. The vaginal tamponade is contraindicated in acute salpingitis. The pressure from it would cause pain and do more harm than good. Topical treatments, which are so frequently used for salpingitis, are of little or no value. Nature, without much aid from the physician, must be given credit for these cures. The general treatment of the patient is of much more importance than the local medicinal treatment of the disease. Attention to rest and care as to violent exercise, are of extreme importance. Anodynes in the chronic form are usually inadvisable.

ON THE NUMBER OF OVA IN THE GRAAFIAN FOLLICLE.

J. E. Welch (Bul. of the Lying-in Hospital, Vol. III, No. 4) reports an interesting case in which by a chance examination, two ova were found in the same Graafian follicle. It is assumed by many histologists that only one ovum is developed in this structure, yet considering the manner of its development, there seems to be no reason why more than one ovum should not be found. At any rate there does not seem to be any publication extant containing an illustration of this condition in the human subject.

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In Welch's specimen, one of the two ova is situated near the surface, the other is opposite towards the medulla of the ovary.

A CONSIDERATION OF 1,446 OCCIPUT POSTERIOR CASES.

J. A. Harrar (Bul. Lling-in Hospital, N. Y., Vol. III, No. 4) found 1,446 cases of persistent occiput posterior in 41,800 observed labors at or near term. Of these 1,013 were spontaneously delivered occiput to the rear, while 433 required artificial assistance to terminate labor. Manual correction alone sufficed in 25 instances; forceps were used 286 times; version was performed 100 times, and craniotomy was done in 22 cases. As to the relative frequency of the third and fourth positions, it is found that the ratio of the right and left posterior positions is 18 to 1, in the cases that spontaneously rotate anteriorly during labor, while in the persistently posterior cases the ratio is 4 to 1. This emphasizes the fact that the occiput in the right posterior position is more likely to rotate anteriorly than in the left. The length or position of the cord is not a factor in the etiology. The membranes rupture in the first stage in one-fifth of normal vertex cases, while in persistently posterior positions of the occiput the membranes rupture in the first stage in one-half of the cases. The perineum is no oftener lacerated than in anterior cases, except in those cases where the head is pulled through with forceps with the occiput posterior, when the worst tears may occur. The maternal mortality is not increased. The fœtal mortality varies with the various methods of delivery. Including the deaths in the first few days, it was 9 per cent in the present series. High forceps in cases with the head arrested at the brim, occiput posterior, gave better results than version. The best procedure for the child in cases with the head in mid-pelvis was manual rotation followed by application of the forceps. In manual rotation great stress is laid upon the importance of external manipulation on the body of the child assisting the internal manipulation of the head in the vagina. In clinching the diagnosis, the author calls attention to the order of overlapping of the cranial bones. The parietals over the occiput and the lower or persisting parietal over its fellow. There are two distinct classes of persistent O. P.

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cases: (a) Those which there is an easy passage for the fetus, either from its small or relative size, and the course and sequelæ of labor compare favorably with anterior cases; (b) Those in which artificial aid should be instituted, and as soon in the judgment of the accoucheur a spontaneous labor is dangerous or impossible. Two signs point to impending failure of rotation: (1) Delay in the advance of the head with strong pains, and (2) a regular advance of the head in mid-pelvis, with gradually increasing extension.

GOUT OF THE FINGERS AND TOES.

Dr. J. V. Shoemaker, in the *Medical Bulletin,* in a case of gouty inflammation of the fingers and toes, accompanied by swelling of the extremities, extreme nervousness, headache, high arterial tension. The blood condition was good, the urine highly colored, acid, specific gravity, 1,029; uric acid, abundant; no albumen or sugar. The doctor prescribed locally for the fingers and toes, three times a day, pure oil of gaultheria, which gave immediate relief; galvanism 10 to 20 milliamperes once daily. To act more decidedly on the gouty system he prescribed the following:

℞ Strychniæ sulphate.....gr. 1-60
Arsenic trioxide.....gr. 1-30
Soluble iron pyrophosphate.....
Quiniæ sulphate .....aa gr. 1

M.—Fiat pil no ds. Take one pill after meals and at bed time. The improvement was marked and continuous.

SEIDLITZ POWDERS EFFERVESCING INTERNALLY.

Scoville reports that he saw many cases of headaches at a food fair brought on by overindulgence in all sorts of edibles. He found the ordinary headache powder inefficacious, so administered Seidlitz powders, the two portions being dissolved separately and drank separately, the effervescense taking place in the stomach. In no case was there discomfort from the effervescence, and every case showed quick relief. He states that a Seidlitz pow-

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der yields about a pint and a half of carbon dioxide at the body temperature, and it is his opinion that this gas is an effective corrective of stomach disorders.

THYROID EXTRACT IN HAY FEVER.

Pottier reports three cases of hay fever treated by this means in the *Journal de Medicine de Paris,* April 7, 1907. He gave the remedy in doses of 10 centigrammes or gr. 1 1-2. One or two pills daily till 25 or 30 are taken usually suffice for a cure.

ADRENALIN AND ATHEROMA.

Adrenalin has been shown by Pearce and Miller to cause definite changes in the walls of the arteries even after but brief administration. Atheromatous patches with definite fibrosis and patches of calcification have been repeatedly found in cases in which adrenalin preparations have been exhibited. These facts should be born in mind by those who use cocaine and adrenalin in treatment.

IN SCIATICA.

Perineural injections of normal salt solution is usually followed at once by relief from pain, which striking result is not always permanent. However, when the pain returns it is usually amenable to milder measures. No bad effects are noticed. It is customary to inject 50 to 100 grammes of a 0.6 per cent solution. The patient complains of pain and tingling in the limb as the needle approaches the nerve. A few instances require the repetition of the injection. Sometimes larger quantities up to 170 cubic centimeters are injected. It is truly remarkable to see patients walking about free from pain the day after the injection. In many cases the results seem as good with the injection of the normal salt solution as when the anesthetics, cocaine or eucaine are added, and this renders it preferable, as the technique is so simple and free from danger, and obviates the fear from idiosyncrasy to the drug.

Pilocarpine nitrate, hypodermically on alternate days for two or three weeks is beneficial contraindicated when there is organic heart disease.

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In the hospital treatment of the natives of India it is customary to inject subcutaneously over the sciatic nerve at a point where the nerve stretching incision is made 10-20 of pure chloroform. In some cases this treatment is wonderfully efficacious. In some it fails. Some pain is caused at first, but it soon passes off. Injurious effects have not been seen to follow. Outside of this the ordinary treatment is 20 grains of salicylate of soda, with one grain of opium.

Sciatica is often due in women to disease within the pelvis. This consists of various pelvic inflammations, and especially retrodeviations aof the uterus. The treatment in these cases consists naturally of first of all the treatment and cure of these pelvic trouble.

The drug treatment of sciatica: Primarily a calomel purge followed by salts. Caution with morphine; in rheumatic cases salicylates, in syphilitic iodides, in gout colchicum. The following is probably one of the best all round prescriptions:

℞ Acid salicylici acetyl. ----------4.00
Acetphenetidivi ----------3.33
Quninæ salicylatis ----------1.33
Codeinæ sulphatis ----------0.25

M.—Fiant capsulæ No. 20. Signa.—Take one every two hours.

The following prescription is indicated in syphilitic and rheumatic subjects:

℞ Potassii iodidi ----------16.00
Sodii salicylatis ----------24.00
Tinct. cimicifugæ, syr. sarsap. compositæ aa--69.00
Aqua, q. s. Ad.----------180.00

M. S.—Take one teaspoonful in water after meals.

Alcoholic sciatica is best treated by the following:

℞ Tincturæ nucis vomicæ,
Fluid ext. hydrastis,
Fluid ext. cimicifugæ aa----------15.00

M. S.—Take twenty drops three times a day and at bed time, increasing the dose one drop every day.

Blisters, counter irritation and painting with iodine are at times quite beneficial.

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Extracts from Home and Foreign Journals.

SURGICAL

A Rare Affection of the Maximus Muscle.

In a recent issue of *Russkii Vratch,* M. M. Kouznetzoff describes a rare condition of the gluteus maximus muscle, in consequence of which the patient, by a voluntary contraction of the muscle, is able to slip its anterior fibers over the trochanter major, producing a crepitus and an audible click. The condition may easily be mistaken for another affection, namely, habitual voluntary dislocation of the hip. The author quotes the two reported cases of Ferraton and Bayer *in extenso* and adds two cases of his own. Both of these were in soldiers, and the peculiar condition interfered with their work, causing pain and disability. The relations of the great trochanter to the Roser-Nelaton line and to Bryant's triangle were normal; all motions in the hip joint were normal and free; the click could be felt to be superficial when the hand was placed over the trochanter and the patient contracted the muscle; at times the fibers of the muscle and its tendon could be felt gliding over the trochanter. Thus habitual dislocation of the hip was excluded. The cause of the condition is probably to be found in changes in the tendon of the muscle and abnormal mobility of its insertion.—*Medical Record.*

Rectal Anesthesia.

Drs. Brewer and Peck, at the Roosevelt Hospital, New York, are using rectal anesthesia with gratifying success. Dr. Berry, in a recent letter to the *Alabama Medical Journal,* says, "the patient is started with ether, and in a few moments the cone is removed from the face, an ordinary rubber tube is inserted four to six inches up the rectum, and by means of an ordinary bulb (hand) syringe attached to the other end of the tube, ether is pumped into the rectum. The operation is a simple thing. It

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has a return tube also which lets the gas escape from the rectum. I saw Dr. Peck do a thyroidectomy, a laparotomy, an operation for undescended testicle, and wire a fractured femur, employing nothing but the rectal anesthesia. I have never seen patients do better than they did—no bronchial irritation or congestion, no vomiting, no unpleasant symptoms in the least. Dr. Peck says also that no proctitis ever follows the use of the rectal tube. Altogether he thinks this way of anesthetising a patient is a marvelous improvement over the old method, especially when it comes to operations on the head or neck and when you wish to avoid any bad after-effects of your anesthesia.—*The Medical Herald.*

Femoral Hernia.

Operations for the cure of femoral hernia have kept pace in complexity and variety with those suggested for inguinal hernia.

But I fully agree with Ochsner and Coley that the complicated methods have nothing to recommend them; in fact they are followed by a greater percentage of recurrences than after the simpler operation. Suppose again that the femoral sac has been exposed, opened and its contents dealt with. Dispose of it in exactly the same way as advocated for the sac in inguinal hernia, and for exactly the same reasons. Close the femoral opening by a purse string or interrupted sutures that firmly unite the end of Poupart's ligament to the pectineal fascia immediately over the pubic bone, and from Gimbernat's ligament outward to the femoral vein.

This method is curative; in fact it is more effective than any of the numerous plans offered for raising fascial and even bone flaps, transplanting the insertion of Poupart's ligament, etc. It really seems as if many surgeons had devised some particular scheme without any regard for the anatomical construction of this region in order that they might tag the operation with their own name, and thus erect a monument to themselves.—*New York State Journal of Medicine.*

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Intermittent Hydronephrosis.

Cheyne reports two cases, in which he employed a modification of the usual method of dealing with the upper end of the ureter. An oval piece of the pelvis of the kidney containing the orifice of the ureter is excised, the greater extent of the oval being above the ureter. As the lower part the incision runs about a quarter of an inch below the point where the ureter leaves the pelvis, at the sides it is carried out to about half an inch, and at the upper part rather more. This piece being detached the orifice of the ureter is inspected and one blade of a pair of scissors is introduced into the ureter not quite down to the point where the ureter loses connection with the pelvis, and the other blade being on the pelvic surface the scissors are closed and in this way a slit-like opening is made and the valvular orifice is got rid of The wall of the ureter and that of the pelvis along this cut, and more especially at the lower angle, are now united by three or four fine catgut sutures. A piece of the lower part of the dilated pelvis is now cut away corresponding in size and shape to the above, and the ureter is then fastened into this opening by a series of Lembert catgut sutures. If deemed advisable a portion of the dilated pelvis may now be cut away and the opening stitched up in a linear direction. If possible it is well to avoid any connection between this incision and that in which the ureter is attached, as leakage is apt to occur at the angle of union.—*Journal A. M. A.*

MEDICAL

Impaction of Feces.

Lewis H. Adler defined impaction of feces as an accumulation of feces in the ampulla of the rectum or the sigmoid flexure. It is usually accompanied by diarrhea, which may be obstinate. It results from intestinal atony in old people, or from paralytic affection. The movements have a peculiarly offensive odor. Extensive ulceration may supervene. Hypochondriacal symptoms are frequent. Examination shows dullness over the

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iliac fossa. Treatment consists of removal of the mass by softening it in some way by enemata and then assisting by the use of a spoon in dislodging the mass. Inspissated ox-gall and glycerine are useful in the enema. Caution should be used in prescribing drastic cathartics, as rupture of the intestine may result. Inflammation may be relieved afterward by the use of enemata of flaxseed tea, medicated with icthyol or benzoin. Remedies must then be used to stimulate the bowel to normal action.—*Medical Record,* September 7, 1907.

The Early Signs of Tuberculosis.

Tuberculosis in most cases is pretty well entrenched into the system before the microscope reveals the presence of the tubercle bacillus. The main purpose of the microscope, then, is to confirm the diagnosis which we have already made by microscopic means. Here are a few of the early diagnostic signs that are quite dependable: A dry, hacking, persistent cough, loss of weight, strength and appetite, an early morning temperature of less than 98 degrees. When the majority of these signs are present it should be a danger signal and we should go to work in earnest in the endeavor to build the patient up before the disease has made far inroads into his system. At present the treatment of consumption resolves itself into hygiene and dietetics.—*Medical Summary.*

Morphin in Asthma.

Goldschmidt believes that fully 50 per cent of the persons addicted to morphin have been victims of asthma. Notwithstanding this, he advises treatment of asthma with morphin, remarking that it is astonishing what small doses will give relief. From 3 to 5 mg. at most will generally cut the attack short and ensure a night's sleep. He has had patients who took these small doses for months at a time, without symptoms of morphin poisoning or addiction to the drug, and it was discontinued without the slightest trouble when the asthmatic condition subsided.—*The Journal.*

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OBSTETRICAL.

Telling the Time of Labor.

When a boy I heard one in whose judgment I had full confidence, but who had devoted much more time to formulating opinions than to acquiring the art of tempering his expressions to sensitive ears, enunciate the following opinion: "The man who attempts to prophesy the exact time of labor is an ass."

A vaginal examination will reveal facts tending to assist us in arriving at an opinion on this point. If the cervix is beginning to shorten the time of labor is usually near at hand, but in women who have previously borne children the infra-vaginal portion may be entirely taken up long before the onset of labor. Indeed, I have had women come to the office for examination in whom the os was as large as a quarter, and the edge thin, and have found a few hours later, with corsets removed, that the dilatation had entirely disappeared. On the other hand, the infra-vaginal cervix is frequently not shortened until after the onset of real labor.

Personal experience has led me to qualify the opinion expressed above. He who attempts an exact prophecy as to the time of delivery may not *be* an ass, but he certainly acts like one. —*The Lancet-Clinic.*

The Determination of Sex: Is It Subject to the Law of the Survival of the Fittest?

Arthur H. Jackson, Los Angeles, says that we have ample ground for abandoning the theory that the male is a factor in sex determination. It seems evident that the ovum contains both male and female elements, and a separation of the two elements in the ovum before it is fertilized occurs. But since fertilization occurs after the maturation of the ovum we must look elsewhere than to the spermatozoon for the factor which causes the elements to divide. Since the female has no voluntary power over sex it is probable that the female element has no power to cause this division. Hence the mother as a factor must be excluded.

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The struggle for the fittest in the ovum may be the determining cause, the weakest polar bodies going under, and the stronger going on to development.—*Medical Record,* September 7, 1907.

Artificial Dilatation of the Cervix.

Jardine justifies artificial dilatation of the cervix to hasten delivery at full term, when demanded in the interests of the mother or child, or both, but condemns it when undertaken merely to save the time of the obstetrician. He describes the most appropriate methods of producing dilatation—by rubber bag, vaginal plug, manual and bimanual dilatation, expanding dilators, multiple incisions of the cervix, and vaginal Cesarean section. He lays stress on the fact that in deciding on the best operation to perform in any case, the obstetrician must be guided not only by the condition of the cervix, but also by the amount of his experience. In antepartum hemorrhage, especially when due to placenta prævia, the vaginal plug or Champetier de Ribes' bag should be used. He deprecates either abdominal or vaginal Cesarean section in placenta prævia. In cases other than antepartum hemorrhage, when the cervix is rigid and the os only admits the finger, manual dilatation will probably be impossible; Bossi's dilator may succeed, but it must be used with very great caution. If the cervix is taken up, the best method is that of multiple incisions; but if the cervix is uneffaced, Cesarean section is the operation of election. Duhrssen's operation for vaginal Cesarean section by perineal vaginal incision is described. —*The Journal A. M. A.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

(Thirty-third Annual Meeting.)

Columbus, Ohio, October 8, 9, 10, 1907.

The thirty-third annual meeting of the Mississippi Valley Medical Association will be held at Columbus, O., October 8, 9 and 10, 1907, under the presidency of Dr. H. Horace Grant, of Louisville, Ky. The orator in Medicine will be Dr. Geo. F. Butler, of Chicago, Ill., and the orator in Surgery Dr. Frank D. Smythe, of Memphis, Tenn.

The Association is doing commendable work in furthering the cause of medical research, by offering a prize of $100 for the best original essay upon some medical or surgical topic. The Committee of the Association to decide upon this contest is composed of Drs. Hugh T. Patrick of Chicago, C. H. Hughes of St. Louis, and A. H. Cordier of Kansas City.

Preparations are being made on an extensive scale for the entertainment of members and guests by the profession of Columbus, with the following Committee of Arrangements: Chairman, F. F. Lawrence; Secretary, Chas. J. Shepard; Treasurer, William E. Davis; Committee Ways and Means, J. W. Clemmer; Entertainment, J. U. Barnhill; Transportation, W. J. Means; Exhibits, W. J. Means; Reception, J. H. J. Upham; Press and Information, Frank Winders; Halls and Meetings, Earl Gilliam; Badges, J. E. Brown; Registration, Wells Teachnor; Ladies, Mrs. W. D. Hamilton.

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The following is a list of papers which have been offered up to August 15th, and there are many promises for papers from other well-known men in the Valley:

I. A. Abt, Chicago, Ill., "Urinary Infections in Children;" Chas. J. Aldrich, Cleveland, O., "The Psychoses of Pneumonia;" M. A. Austin, Anderson, Ind., "The Kidney Surgically Considered;" Carl Beck, Chicago, Ill., "Gastric Ulcer;" M. R. Burker, Chicago, Ill., "When Should Gastric Ulcer Be Treated Surgically?" A. D. Barr, Jersey City, N. J., "The Relation of Metabolic Ferments to Metabolism, Especially in Diabetes Mellitus and Tuberculosis;" Chas. E. Barnett, Ft. Wayne, Ind., "Vesico-Urethro-Vaginal Fistula;" J. E. Cannaday, Hansford, W. Va., "Treatment of Pus Tubes;" T. D. Crothers, Hartford, Conn., "The Relation of the Doctor to the Alcoholic Problem;" Geo. B. Evans, Dayton, O., "Local Anesthesia versus General in Ano-Rectal Surgery;" Geo. W. Finley, Brazil, Ind., "Gastro-Enteritis;" Frank W. Gavin, Canton, O., "Medical Inspection of Public Schools;" A. E. Halstead, Chicago, Ill., "Cancer of the Thyroid Gland;" M. L. Heidingsfeld, Cincinnati, O., "Some Clinical and Differential Features of Syphilis, as Demonstrated from Lantern Slides and Wax Models;" Earl Harlan, Cincinnati, O., "The Frequent Inter-dependence of Dislocated Kidney, Gall-Bladder Trouble, and Appendicitis;" Marc Ray Hughes, St. Louis, Mo., "Anomalies of the Stigmata of Degeneracy;" G. Frank Lydston, Chicago, Ill., "Plastic Work on the Urethra—A New Operation;" Harold A. Miller, Pittsburg, Pa., "Pregnancy Complicated by Pulmonary Tuberculosis;" J. B. Murphy, Chicago, Ill., "Pleuritis and Its Surgical Aspects;" C. M. Nicholson, St. Louis, Mo., "Primary Abdominal Pregnancy;" Curran Pope, Louisville, Ky., "The Value of Physio-Therapeutic Methods in Chronic Diseases;" D. C. Peyton, Jeffersonville, Ind., "Tuberculosis of the Bones of the Feet, with Its Treatment;" Chas. A. L. Reed, Cincinnati, O., "Important but Frequently Disregarded Clinical Phases of Movable Kidney;" Merrill B. Ricketts, Cincinnati, O., "Treatment of Stump in Appendectomy;" H. H. Roberts, Lexington, Ky., "Gastric Ulcer;" Albert E .Sterne, Indianapolis, Ind., "Radical and Palliative Operations for Cerebral Hemor-

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rhage;" Mark D. Stevenson, Akron, O., "Purulent Conjunctivitis in Infants and Adults;" Geo. P. Sprague, Lexington, Ky., "Drug Addictions;" Geo. B. Twitchell, Cincinnati, O., "Internal Rotation and Lacerations of the Perineum;" Frank B. Walker, Detroit, Mich., "Treatment of Inguinal Hernia in Children;" Edwin Walker, Evansville, Ind., "What We Cannot Do with Purgatives;" A. U. Williams, Hot Springs, Ark., "Some Cases of Reinfection with Syphilis;" C. E. Briggs, Cleveland, O., "Volvulus of the Entire Mesentery of the Small Intestine, with Report of a Case;" Sanger Brown, Chicago, Ill., "Medicolegal Notes;" J. Rawson Pennington, Chicago, Ill., "The Sigmoidal Factor in Pelvic Diseases;" Bernard Asman, Louisville, Ky., "Cancer of the Rectum;" Robt. C. M. Lewis, Marion, O., "Neuroses of the Bladder;" Hugh F. Lorimer, Chillicothe, O., "The Early Diagnosis of Gall-Stones."

Penal Code State of New York.
(Amendment to Section 401.)

Section 401 of the Penal Code has been amended so as to read as follows:

Any person, who, in putting up any drug, medicine or food or preparation used in medical practice, or making up any prescription, or filling any order for drugs, medicines, food or preparation puts any untrue label, stamp or other designation of contents upon any box, bottle or other package containing a drug, medicine, food or preparation used in medical practice, or substitutes or dispenses a different article for or in lieu of any article prescribed, ordered or demanded, or puts up a greater or less quantity of any ingredient specified in any such prescription, order or demand than that prescribed, ordered or demanded, or otherwise deviates from the terms of the prescription, order or demand by substituting one drug for another, is guilty of a misdemeanor; provided, however, that, except in the case of physicians' prescriptions, nothing herein contained shall be deemed or construed to prevent or impair or in any manner affect the right of an apothecary, druggist, pharmacist or other person to

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recommend the purchase of an article other than that ordered, required or demanded, but of a similar nature, or to sell such other article in place or in lieu of an article ordered, required or demanded, with the knowledge and consent of the purchaser. Upon a second conviction for a violation of this section the offender must be sentenced to imprisonment, for a term of not less than ten days nor more than one year, and to the payment of a fine of not less than ten dollars nor more than five hundred dollars. The third conviction of a violation of any of the provisions of this section, in addition to rendering the offender liable to the penalty prescribed by law for a misdemeanor, shall forfeit any right which he may possess under the law of this state at the time of such conviction, to engage as proprietor, agent, employe or otherwise, in the business of an apothecary, pharmacist or druggist, or to compound, prepare or dispense prescriptions or orders for drugs, medicines or foods or preparations used in medical practice; and the offender shall be by reason of such conviction disqualified from engaging in any such business as proprietor, agent, employe or otherwise, or compounding, preparing or dispensing medical prescriptions or orders for drugs, medicines or foods or preparations used in medical practice.

SECTION 402. This act shall not affect or impair any liability, penalty or punishment under the provisions of section four hundred and one as the same existed prior to the time this act takes effect, but the same may be enforced, prosecuted or inflicted as fully and to the same extent as though this act had not been passed; and all action civil or criminal instituted under or by virtue of said section as the same existed prior to the passage of this act, and pending immediately prior to the taking effect hereof, may be prosecuted and defended to final effect in the same manner as though this act had not been passed.

SECTION 403. This act shall take effect September first, nineteen hundred and seven.

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ANATOMIST (MALE). ARMY MEDICAL MUSEUM. OCTOBER 23-24, 1907.

The United States Civil Service Commission announces an examination on October 23-24, 1907, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill a vacancy in the position of anatomist (male), at $1,600 per annum, in the Army Medical Museum, office of the Surgeon-General, and other similar vacancies as they may occur there.

The examination will consist of the subjects mentioned below, weighted as indicated:

Subjects.	*Weights.*
1. Human anatomy	40
2. Anatomical drawing (competitors will be required to make a pen-and-ink drawing from a photolithograph which will be furnished)	20
3. Gross pathology (of tissues)	15
4. Construction, care, and use of microscope (questions relating to the compound microscope, with knowledge of various makes in general use)	10
5. Training and experience (rated on application)	15
Total	100

Two days will be required for this examination. The first subject will be given on the first day, and the remaining subjects on the second day.

Age limit, 20 years or over. Only male applicants will be admitted to examination.

It is desired that the person appointed to this position should be young, in good health, have a thorough knowledge of anatomy (preferably, but not necessarily, a graduate in medicine), be able to make anatomical drawings, understand microscopes, surgical instruments and appliances, and be able to prepare, card, and keep in order the anatomical specimens of the museum.

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This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application Form 1312. No application will be accepted unless properly executed, including the medical certificate, and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued September 2, 1907.

American Roentgen Ray Society Annual Meeting, Cincinnati, Ohio, October 2, 3, 4, 1907.

Preliminary program of the Cincinnati meeting:

"Senility and its Roentgenological Aspects"—Dr. Percy Brown, Boston, Mass.

"Specific Immunity and *X*-ray Therapeutics"—Dr. A. W. Crane, Kalamazoo, Mich.

"Superior Results in Fractures Obtained by Radiographic Examinations"—Dr. Arthur Holding, Albany, N. Y.

"The Early Radiographic Diagnosis of Pulmonary Tuberculosis"—Dr. Lewis Gregory Cole, New York.

"Some Experiments with *X*-ray Tubes"—V. J. Willey, Ann Arbor, Mich.

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"Stereoscopic Radiography"—Dr. Max Reichmann, Chicago.

"Report of Cancer Cases Treated with the *X*-ray and Comments Thereon"—Dr. Ennion G. Williams, Richmond, Va.

"Goitre"—Dr. George C. Johnston, Pittsburg, Pa.

"A Roentgenological Contribution to the Study of the Constipating Effects of Morphine upon Human Beings"—Dr. Henry Hulst, Grand Rapids, Mich.

"Protection of the Operator"—Dr. Charles L. Leonard, Philadelphia.

"Protection of the Patient"—Dr. Russell H. Boggs, Pittsburg, Ta.

"The Post-Operative Treatment of Carcinoma"—Dr. Walter C. Hill, Cleveland, Ohio.

"The Treatment of Sarcoma"—Dr. G. E. Pfahler, Philadelphia, Pa.

"The Histogenesis and Diagnosis of Benign Bone Cysts"—Dr. George P. Muller, Philadelphia, Pa.

"Preliminary Report Upon a More Rational Method of Treating Leukemia by the *X*-ray"—Dr. Henry K. Pancoast, Philadelphia, Pa.

"A Further Study of the Action of *X*-rays in Leukemia"—Dr. oseph F. Smith, Chicago, Ill.

"Lantern Slide Demonstrations of Some Types of Arthritis" —Dr. Albert H. Freiberg, Cincinnati, Ohio.

"Marking and Storing Negatives"—Dr. W. S. Newcomet, Philadelphia.

"An *X*-ray Unit Demonstrated by a Standardized Meter"—Samuel Allen, Ph. D., Cincinnati, Ohio.

"President's Address"—P. M. Hickey, M.D., Detroit, Mich.

The eighth annual meeting of the American Roentgen Ray Society promises to be the most successful in the history of the Society. A glance at the preliminary program shows a variety of subjects of interest to Roentgenologists, which will be under discussion at this meeting. The exhibit of negatives under the direction of Dr. Percy Brown will be of extreme interest and distinct educational value.

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The convention hall can be completely darkened, and an excellent lantern in the hands of a competent operator has been secured, so that lantern slide demonstrations may be made to illustrate the various papers. The exhibit of apparatus will show the best efforts of the most prominent manufacturers in the country, and a number of new and interesting devices, some of them of great value, will be shown. There will be a large exhibit of *X*-ray tubes of several prominent makers, and an opportunity of selecting suitable tubes after observing them in operation on the various forms of apparatus will be a pleasure to those members of the Society who are interested, and who purchase ordinarily by order without the opportunity of testing the apparatus.

The convention, exhibit and hotel accommoditions for the entire Society have been arranged for under one roof. Accommodations may be obtained either upon the American or European plan. The rates on the American plan are $3 per day per person, and up.

The railroads have refused to grant a special rate on account of the two-cent fare in Ohio, but this fact will not decrease the attendance at the meeting.

Arrangements have been made for the entertainment of the visiting ladies, Mrs. Kennon Dunham being chairman of the entertainment committee.

A large number of applications for membership have been received, and an extremely profitable meeting is assured.

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Reviews and Book Notices

A Manual of Hygiene and Sanitation, by Seneca Egbert, M.D., Professor of Hygiene in the Medico-Chirurgical College, Philadelphia. New (fourth) edition, thoroughly revised. 12mo, 498 pages, with 93 illustrations. Cloth, $2.25, net. Lea Brothers & Co., Philadelphia and New York, 1907.

The fourth edition of this valuable up-to-date manual is before us. It will prove of excellent service to every one interested in this important subject, and is admirable for the exhaustive and yet condensed form in which the subject matter has been presented. We unhesitatingly commend the publication as a splendid exposition of the subject.

A Manual of Clinical Diagnosis, by means of Microscopic and Clinical Methods, for Students, Hospital Physicians and Practitioners, by Chas. E. Simon, B.A., M.D., formerly of the Resident Staff of the Johns Hopkins Hospital; Professor of Clinical Pathology, at the Baltimore Medical College; Clinical Microscopist to the Union Protestant Infirmary. Sixth Edition, Thoroughly Revised. Illustrated with 177 Engravings and 24 Plates in Colors. Lea Brothers & Co., Philadelphia and New York, 1907.

The sixth edition of this popular and valuable hand-book is before us. The work has undergone a thorough overhauling, bringing it fully abreast with the times, and while much new material has been added, the size of the book has not been perceptibly increased. To do this it was necessary for the author to practically rewrite the work, and to cut out everything that was not clearly of practical value. We commend the work as a most useful one to practitioners and students.

Progressive Medicine, a Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, etc. Assisted by H. R. M. Landis, M.D., Visiting Physician to the Tuberculosis Department of the Philadelphia Hospital, to the White Haven Sanatorium, and to the Phipps Institute; Demonstrator of Clinical Medicine in the Jefferson Medical College. Volume III, September, 1907. Diseases of the Thorax and its Viscera, including the Heart, Lungs, and Blood Vessels. Dermatology and Syphilis. Obstetrics. Diseases of the Nervous System. Lea Brothers & Co., Philadelphia and New York, 1907.

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We take great pleasure in asking the attention of our readers to this excellent quarterly publication, very correctly entitled "Progressive Medicine." Its objects are to lay before the profession in attractive form the most recent advances and developments that are taking place in every department of medicine and surgery, culling the choicest bits of the flowers that bloom, not only in the spring, but all through the year. We have always regarded this publication as one of the most thoroughly practical and advantageous periodicals now being published, and each successive number seems to strengthen our appreciation of its great value. The contributors to the September number are Drs. Edw. P. Davis, William Ewart, Wm. S. Gottheil and Wm. G. Spiller, all recognized authorities on the branches they represent.

Thirty-third Annual Report of the Secretary of the State Board of Health of the State of Michigan, for the fiscal year ending June 30, 1905. Wynkoop, Hallenbeck, Crawford Co., State Printers, Lansing Michigan, 1906.

Much material of interest will be found in this report, which is an annual visitor to the editor's table. It serves to show the amount of careful, painstaking work done by one of the best State Boards of Health in this country, and contains much that will prove interesting and instructive to all interested in sanitary medicine.

A Text-Book of Physiological Chemistry. For Students of Medicine and Physicians, by Charles E. Simon, M.D., Professor of Clinical Pathology in the Baltimore Medical College. New (third) edition. In one Octavo Volume of 490 pages. Cloth, $3.25, net. Lea Brothers & Co., Philadelphia and New York, 1907.

We are in receipt of the third edition of this well-known text-book, intended to serve as a guide in laboratory work, and as a lecture room *vade mecum.* The book has been brought in this revision fully up to date without increasing its size. The growth of this important branch of medicine has been of late so rapid that this part of the author's task has been rendered unusually difficult, but he has succeeded admirably in doing so without in any way impairing the value of the work.

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Publisher's Department

An Ideal Agent in the Treatment of Enteritis in Children.

BY C. EVERETT FIELD, M. D., NEW YORK CITY.

It is among the poorer classes of large cities that we find the greatest number of cases of *enteritis* in children, due to a great extent to improper food or the faulty administration of food. These factors, together with the congestion of the living districts and the summer heat, are largely responsible for the mortality. Of course, even under favorable circumstances cases may occur, yet the statistics of our large municipalities bear testimony to the many little lives that are sacrificed among the poorer classes on account of *enteritis*. In the treatment of these diarrheas there are certain fundamental necessities. One is to withhold all solid food, and in some cases all food for a time, varying according to the character and severity of the attack. I am accustomed, when summoned to a case of acute dyspeptic diarrhea (the most common form) to withdraw all food for from twelve to twenty-four hours, excepting some albumen water, to which I usually have added a little whisky, from five to ten drops in complicated cases, to ten to twenty drops in cases where collapse is threatening, and subsequently modifying the diet according to the indications in each particular case.

The second necessity is to promptly and efficiently clean the intestinal tract. For this purpose I use calomel in 1-10 grain doses every half hour, giving from one to two grains, according to age of child. Yet this is not sufficient, for the most effectual purgation will often not remove the fermentation from the gastro-intestinal canal. To overcome this I know of nothing more prompt or efficient than Glyco-Thymoline.

After the calomel has acted, and even some time before in many cases, I add two tablespoonfuls of Glyco-Thymoline to a pint or a pint and a half of hot water (about 100°), which I slowly inject into the rectum and colon by means of a flexible

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rubber catheter. In addition, I order teaspoonful doses of Glyco-Thymoline by the mouth every two or three hours, and sometimes every hour.

The suspension of food, evacuation of bowel contents, irrigation of colon and correction of acidity by means of Glyco-Thymoline per rectum and peros, followed by proper feeding and hygiene, constitutes the usually effective plan of treatment in otherwise uncomplicated cases of acute dyspeptic diarrhea of infants and young children.

Regarding Glyco-Thymoline, I have used it in cases of acute dyspeptic diarrhea in which the acidity was corrected within from seven to eight hours. As it can be administered with impunity, it is a valuable agent both for irrigation purposes as well as a corrective for the stomach. I have for some time abandoned the normal salt solution for Glyco-Thymoline as an irrigating fluid in the large intestine. Glyco-Thymoline possesses all these advantages with the additional one of being mild in its action as an *antacid,* and yet a powerful one, while it acts as a stimulant when hot, not only systematically like the salt solution, but locally upon the mucous membrane of the bowels, a fact that I have often observed.

The following case is one of those in which Glyco-Thymoline has given me excellent results:

A. W., age seven months, had an increase in the number of stools, and had shown considerable irritability for some days. The stools showed fermentation, were green, contained curds, and were very offensive. There was considerable abdominal pain, temperature 103°F. There had been slight vomiting. All food, excepting albumen water, was cut off. A calomel purge was given (gr. 1-10 every half hour until 1½ grs. had been taken). This was followed by a teaspoonful of phosphate of soda well diluted in a glass of water, one teaspoonful of this solution being given between the doses of calomel. The bowels were irrigated with hot Glyco-Thymoline solution, and after they had been thoroughly acted upon by the calomel, teaspoonful doses of the Glyco-Thymoline were given hourly by the mouth. Within eight hours the diarrhea had stopped, the temperature was only 99½°,

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and the attack had practically ceased. The irrigations with Glyco-Thymoline, two tablespoonfuls to the pint, were continued daily, night and morning, with astonishing and prompt results.

Antiphlogistine Versus Opium.

Inflamed states of the various organs of the body frequently give rise to pain of such urgent character as to demand active steps looking to its relief. Upon seeing the patient for the first time (he has called his physician because his suffering has become intolerable), the medical attendant is met with a peremptory demand for relief from the suffering.

With a willingness, which frequently overrides their better judgment, some physicians resort to the hypodermic needle indiscriminately, and, in too many cases, a greater evil has followed the lesser one. The free habit of using morphine or some other form of opium is not a judicious practice, and for several reasons. The exact seat of an inflammation, for instance, might become difficult to locate, and thus a clear diagnosis interfered with. But the greater objection to the use of opium is the possibility of adding a recruit to the ever growing army of habitues.

Every time there occurs to a doctor the apparent need for opium he should deliberate wel lbefore resort is had to the needle. If, after careful consideration, has best judgment advises the use of opium, it should be given in some form by mouth. If the needle is used the patient at once knows what he is getting, but he is not so likely to acquire this information if it be given otherwise.

For relieving the pain of the inflammations Antiphlogistine will easily take the place of opium. The relief following may not be so prompt and so complete, but the edge of the suffering is taken off within a short time, and soon the patient is in a comfortable condition and has escaped the possibility of becoming addicted to a drug. There is not the likelihood that a patient, relieved from pain by it, will begin eating or using Antiphlogistine in any other way—which likelihood is the greatest disadvantage of opium.

In the future let your morphine become stale, and keep your *Era.*

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A Suggestion.

The new Glyco-Thymoline Eye Bath, which is constructed from a single piece of aluminum, has been found of exceptional service when used as a vessel to heat hypodermic solutions to the proper temperature. This little hint comes from a physician who has frequently found himself wanting just such a device. The Glyco-Thymoline people will be glad to send you one of these cups if you so desire. C. E. F.

The attention of our readers is called to the advertisement of Robinson-Pettet Company, which appears in this issue. This house is one of long standing, and enjoys a reputation of the highest character. The preparations referred to, we commend specially to the notice of practitioners.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. OCTOBER, 1907. No. 10

Original Communications

THE EARLY DIAGNOSIS AND MANAGEMENT OF PULMONARY TUBERCULOSIS.

BY R. W. FREY, M. D., TRENTON, KY.

MR. CHAIRMAN: I have been assigned the task of writing a paper on "The early diagnosis and management of pulmonary tuberculosis."

On examination of the literature on this subject, I find that very few of our text-books give the earliest symptoms of this disease.

On the other hand, however, I find in our medical journals for the three years past numerous and most excellent articles on the subject.

I will, therefore, quote from very few text-books, but will endeavor to give this Society my own findings and experience for the last four years in the early diagnosis and management of pulmonary tuberculosis.

To my mind, an early diagnosis can hardly be overestimated,

Read at a joint session of the Medical Societies of Robertson County, Tenn.; and Todd and Logan Counties, Ky.; Guthrie, Ky., October 1, 1907.

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for the simple reason that upon an early diagnosis depends very largely the favorable or unfavorable outcome of the case.

Among the earliest diagnostic symptoms mentioned by one of the late English authors on the early diagnosis and treatment of pulmonary tuberculosis, and classed by him as positive symptoms, are as follows:

1st. The presence of the tubercular bacillus.
2d. Hemorrhage.
3d. Diminished resonance.
4th. Increased percussion resonance.
5th. Fine rales.

This quotation was taken from the above author's book, devoted exclusively to the subject of pulmonary tuberculosis. I want to state that with one exception, that of hemorrhage, which symptom in my experience has frequently been the first symptom to manifest itself, instead of the fifth, the author's experience differs very widely from mine as to the early positive symptoms in this disease.

When all the above symptoms are present, any tyro can make a diagnosis of the disease; in fact, the patient, or his friends, have already made a diagnosis of pulmonary tuberculosis for us, and more especially if the patient has had a hemorrhage is this true; it is frequently too late to arrest the progress of the disease after it has reached this stage, as many of us know by past experience with tuberculosis, and it is for this very reason, more than any other, that our treatment of this disease has been such a dismal failure in the past. In my opinion, long before the symptoms given above manifest themselves, there are symptoms when rightly interpreted that will lead to a positive diagnosis allowing these patients to be saved to their families and community.

When these patients come to us, we obtain a history about as follows: They usually state that they have not been themselves of late; they feel run down and easily tire; find that they have been steadily declining in weight and general health for several months. On carefully questioning these patients, we will frequently find that their surroundings are not of the best; coupled with their mode of life, we may find that they have had an op-

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portunity to acquire tuberculosis in some way; frequently some member of the family, or a relative with whom they are or have been associated, has had or still has the disease. Or they may be living in a house that has been infected by tuberculosis in the past. This knowledge is of the utmost importance to the physician in obtaining the history, as this is a frequent source of the disease among the poor and negroes; or they may be one of those unfortunates who has a predisposition to tuberculosis, which, in my opinion, should have great weight with us, both in diagnosis and prognosis.

This history should be followed by a careful physical examination, and we will usually find the following including the above history:

1st. A steady decline in weight and general health, or a hemorrhage without much decline in either weight or health;

2d. Patient is easily fatigued.

3d. Every change in the weather causes them to contract a slight cold.

4th. A slight hacking cough on rising in the morning.

5th. With this cough a little mucus is raised in which we may or may not find the tubercular bacillus.

6th. If the day is dry and fine, the cough soon subsides, at least in a few hours, to be repeated in the morning following, and should the day be cool and damp, the cough will continue through the day and into the night.

7th. An increased frequency of the pulse rate; this pulse being at all times soft and compressible.

8th. A slight rise of temperature every afternoon—this temperature must be taken at the same hour of the day, and under as similar circumstances as possible to be of the greatest diagnostic value.

In my opinion, the above symptoms and history should always cause us not only to suspect, but to pronounce as positive the case as one of incipient tuberculosis, and more especially should this be done if these symptoms have been preceded by a grip, pleurisy or pneumonia. I make it a rule in these cases to confirm or refute my diagnosis by the fluoroscope or shadowgraph, or both.

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It is the opinion of some of our best observers that no case, where possible, should be denied this valuable aid to an early and correct diagnosis, as it is just at this stage of the disease that we can best arrest its progress. I will also state that to any one accustomed to the use of the shadowgraph in the diagnosis of the diseases of the chest, there are hardly any other means that make us feel so sure of our diagnosis as a good shadowgraph. I have had no experience with tuberculine, although it is being used by some good men, both for diagnosis and treatment.

I state most emphatically that all or the greater part of the above symptoms are present before the ones we find mentioned in our text-books, a statement I have been able to confirm many times over.

TREATMENT.

As to treatment by drugs, there is but little to be said; on the other hand, as to the management of these patients, there is a great deal to be said and done to enable them to regain their health.

First, The environments of these patients must be changed; they must be kept out of doors winter and summer when the weather will permit. This can be done by almost any family, however poor, by the erection of a porch all around the house or any building; or by building a shelter or tent near the house in which to sleep or to remain during inclement weather: but at no time should the patient remain indoors or under shelter unless it be on an uninclosed porch. As long as these patients have a rise of temperature, they should be put at absolute rest, both physically and mentally, on a cot or bed. This, in my opinion, is an absolute necessity to the recovery of these patients; a reclining chair or hammock will not do under any circumstances as a makeshift. They should remain at rest until their temperature reaches normal and the pulse 100 or less; then they may be permitted to use the reclining chair and take very moderate exercise; should moderate exercise cause a rise either in temperature or pulse, they must be put back in bed for another season of rest. These patients should be encouraged to sleep all they can, just so it does not interfere with taking either food or water.

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Contrary to much of the former teaching, these patients should be given all the solid food they will take and digest; all "slops" should be avoided as foods, as they so dilute the digestive fluids as to be a positive hindrance to good digestion. Small doses of tincture nux vomica may be given before meals, and muriatic acid dilute after meals; we must use our very best endeavor to bring the digestion up to the highest state of efficiency; these patients must be comfortably clad at all times, as it requires more clothing to keep these patients warm than it does people in good health; they should receive a warm sponge bath once in every twenty-four hours, followed by an alcohol sponge; this sponge bath must be done thoroughly and with the patient reclining, or in the recumbent position, so as to avoid all fatigue to the patient. My preference for the bath is in the morning. These patients should spend a portion of each day in the sunshine when it is not too hot; low temperature should not be considered a barrier if the sun is shining. Hot water bags and blankets may be added for their comfort. I am not an advocate of a change of climate for these unfortunates, for reasons too numerous to be mentioned here.

These patients should have each day, when possible, the benefit of the X-ray light and high frequency currents, followed by some form of static electricity best suited to the individual patient, as they are of almost invaluable worth to these patients in the recovery of their health. I have been following the methods outlined above for four years, with most gratifying results.

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Selected Articles

ADDRESS.

Some General Considerations Regarding Tumors.*

BY W. T. COUNCILMAN, M.D.

When your society honored me by requesting me to give this address I thought it would not be amiss if I should try to give you some of the general views on the subject of tumors which have come to me through their study. In this study the clinical side of the subject has been considered only so far as it has a direct bearing on the pathological side, so I must be pardoned if I touch but lightly the clinical aspect.

The subject of tumors is of perennial interest for the clinician, the pathologist, the embryologist and the medical statistician. The enormous advance in medical knowledge in the past three decades, which has brought to light the essential nature of many of the infectious diseases and thereby given us the indications for their control, which has revolutionized surgery and made it probably the most important branch of medicine, has but lightly affected the subject of tumors. It is true our knowledge of modes of diagnosis and methods of treatment, of structure, of modes of growth, has been increased, and the application of that knowledge to clinical treatment has given brilliant results, but of the essential nature of tumors we know but little more than we did thirty or even sixty years ago.

A tumor is a new formation of tissue which is without function and which has the power of independent and unlimited growth. At some point in the body the cells begin to grow and produce a tissue which may be circumscribed and easily separated from the adjoining parts, or it may be so infiltrated and

*An address delivered before the Maine Medical Association, June 13, 1907.

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closely related with the healthy tissue that it cannot be separated as a distinct mass. The growth arises from the cells of the body, and the structure produced agrees more or less closely with the tissues of the normal body. In some cases there is more analogy with the embryonic than with the adult tissues. The tumor may be composed principally or entirely of cells just as are the embryonic tissues, or between the cells there may be a varying amount of intercellular substance. Considered in its widest relations the tumor is atypical, that is, it does not conform to the type of normal structure. In some cases the tumor may agree exactly with a corresponding tissue in the normal body; thus it may be impossible to distinguish by the most careful microscopic examination the tissue of a myoma of the uterus from the normal muscle of that organ, but the departure from the type is shown by the fact that the tumor forms a circumscribed nodular mass of muscle such as does not appear in the normal uterus.

The tumors are independent structures which live in the body as does a parasite, taking their nourishment from it, but the body as a whole has no influence on the tumor. The nutrition of a tumor is independent of the general nutrition of the body. In cases of general malnutrition all the tissues of the body are affected, some, of course, much more than others, but it is not an uncommon thing to find a rapidly growing tumor in an individual in whom the general nutrition is reduced to a very low degree. The cells of a tumor are independent of the laws governing the general nutrition.

A tumor is without function. No matter how closely its structure may agree with that of some normal structure, it never exerts a corresponding function. One of the most striking examples of this is seen in the lipoma which is composed of fatty tissue which both macroscopically and microscopically agrees with the structure of the normal fat. We know that the adipose tissue is a special form of tissue in which fat is deposited, serving as a nutritional storehouse and increased or diminished in the varying nutrition of the body. Notwithstanding that the lipoma agrees in its structure with the normal fat, it in no way serves the nutrition of the body. I have seen a large lipoma in an in-

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dividual in the last stages of tuberculosis and in whom the normal fat was reduced to the very lowest degree. No matter how strikingly similar the structure of an adenoma may be to that of a normal gland its cells do not produce a corresponding secretion.

The growth of a tumor is independent of the laws governing the growth of normal tissues. We know that in the course of normal development each tissue is produced by a process of differentiation. Tissues which in their full development differ widely both in structure and function are formed from cells of like character. The individual organs and the body as a whole continue to grow until a size is reached which corresponds to the type of the species, when the general growth ceases or is limited to that sufficient to repair loss. The growth of all organs is interdependent; at any time in the period of growth the same relative degree of development and size will be found in the different organs. No organ develops independently of the others; the liver and kidney correspond in size with that of the individual. In certain organs the growth is continuous from the embryonic period to the completion of growth; in others, as in the genital glands, there is a long period of quiescence after the embryonic period, and growth does not actively begin until the onset of puberty. The life of certain tissues is passed quickly. The thymus, certainly an active organ during fetal and for a short post-fetal period, instead of continuing to grow with the rest of the tissues, early undergoes atrophy. All the lymphoid tissues reach their full development early and atrophy instead of continuing to grow with the other organs. Notwithstanding that growth ceases with full development or is limited to the very slight degree necessary to compensate for the wear entailed by function, a considerable energy of growth remains which in various ways can be excited to activity.

Certain tissues and certain organs have a power of regeneration or of reforming tissue which may be destroyed to a very much greater degree than others. In general, the younger the individual the greater the power of regeneration of the tissues; a tadpole quickly regenerates the tail when this has been cut off,

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but the adult frog is incapable of regenerating a limb. The less highly differentiated a tissue the greater the power of regeneration; the slightly differentiated epithelium removed from the surface of the body is quickly replaced, but nerve ganglion cells once destroyed are never renewed again nor can such a complicated structure as a renal glomerulus be renewed. We must assume that there is some means of regulating normal growth. Whether growth is regulated by means of the production of an internal secretion, or whether the regulation is more of a physical nature and due to the mutual relations of pressure is unknown. Certain things show the possibility of the regulation of growth by chemical substances. The thyroid probably has some such influence but the most definite example of the influence of a chemical substance on growth is that of the internal secretion of the corpus luteum. It has been shown that the growth of the mammary gland which accompanies pregnancy may be produced in a non-pregnant animal by the injection of an extract of the corpus luteum. That growth may be stimulated by alteration of the normal relations of the tissues to one another is shown in the repair of injuries. The surest way to excite a tissue to proliferation is by the production of an injury. All repair of wounds is due to this power of growth. Growth thus started by an injury persists until the normal relations of tissue are again established, when it ceases. Growing tissue demands more blood and new blood vessels are formed in it, but hyperemia alone will not excite tissue to grow; the tissue regulates its blood supply.

As compared with the normal tissues the independent growth of a tumor is its most striking charactertisitc. It is lawless, unregulated, and has no relation whatever to the growth of the body as a whole nor to the growth of the different organs. The fetus developing in the uterus of the mother is no more independent in its growth than is the growth of a tumor. Each may be regarded as an independent parasite deriving only nutrition from the host. A tumor begins to grow by certain cells of the body multiplying rapidly and independently. The cells in their general features conform to the cell type of the species but they show an extraordinary degree of variation. The cells of a tumor derived

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from squamous epithelium have the general characteristics of this and those derived from cylindrical epithelium have the general characteristics of cylindrical epithelium. As a rule, from the microscopic examinations of a tumor, we can tell from what sort of tissue it is derived. Cell growth and multiplication in a tumor take place as in normal tissues but present many variations. In normal cell division complicated processes take place in the cells which render it possible for the new cells to have parts of all the contents of the old. In the division of tumor cells the process is much more irregular. New cells are formed which have but a part of the contents of the parent cell, and instead of the cell dividing into two equal parts a triple or fourfold division may take place. It still remains a mooted question whether the tumor, once having started, grows only from itself or whether adjoining tissues can take part in the growth and become a part of the tumor. Certainly, in most cases this does not take place, but I have occasionally seen in tumors of the breast appearances which seemed to indicate that certain of the ducts and other structures of the gland which had become included in the infiltrating growth of the tumor were taking on the same sort of growth and forming a part of the tumor. In certain tumors derived from the skin epithelium I have seen similar appearances in the hair follicles and glands. It is very difficult in these cases to be certain that the apparently normal cells which seem to be changing into tumor cells are not really tumor cells which have replaced the normal cells.

We distinguish in general two forms of tumor growth. One, termed the expansive growth in which the tumor enlarges as from a single center, remains a coherent mass and pushes away the surrounding tissue. Ofter the connection with the surrounding tissue is so loose that no trouble is experienced in the enucleation. Such type of growth is seen in those tumors which contain considerable intercellular substance or in which the cells are woven together to form a compact mass. In the infiltrating mode of growth the cells penetrate into the spaces of the surrounding tissue and in their growth force themselves or are carried by the lymph streams even deeper into this tissue. In such

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a tumor it is impossible to determine the limits of the tumor by the naked eye examination. What appears to be normal tissue may contain numbers of actively growing tumor cells.

Tumors are always connected with the surrounding tissues by blood vessels, and usually by considerable amounts of connective tissue as well. The blood supply varies and depends upon the rapidity of growth of the tissue. Tumors like other tissues make demands upon the blood for their nutrition, and the more active the growth the more abundant is the blood supply. The vessels vary much from the normal and have not the characteristic division into arteries, capillaries and veins. Into a normal organ one or several arteries enter, break up into capillaries and these coalesce to form a system of veins. There is nothing similar in the vascular supply of tumors. From all sides vessels of different caliber and often of capillary structure enter into the tumor, divide and ramify in it without definite arrangement. This is understandable from the development of the tumor which does not take place in a definite arterial territory, but only in a small part of one, and the existing vessels are utilized for nutrition and very greatly enlarged. New vessels are continually being formed to keep pace with the rapid growth, but these have rather the character of the vessels formed in inflammatory tissue and are not differentiated into arteries and veins. Owing to this irregularity of vascular formation the circulation of a tumor is not so perfect as that of a normal part.

In certain tumors, particularly the sarcomas, the vessels for the most part may be mere channels in the tissue lined by a single layer of endothelial cells. The thin walled vessels are easily compressed by the growing masses of cells, and necroses and infarctions, the result of the disturbances of the circulation, are common. In many tumors hemorrhages as a result of rupture of vessels or of necrosis of their walls are seen. Necrosis also occurs as the result of imperfect nutrition, the blood supply not being able to keep pace with the rapid growth of cells. All these degenerations are found chiefly in the center of a tumor, the cells on the outside where they are closed to the blood supply are usually better preserved. In consequence of these degenerations

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connected with insufficient blood supply the size of a tumor may give an imperfect indication of the rapidity of growth, for the central degenerated tissue may be absorbed and replaced by cicatricial tissue which occupies but a small space. The best example of this is given in contracted scirrhus of the breast, the periphery of which may give all the characteristics of a rapidly growing tumor while the center has become converted into a mass of cicatricial tissue containing but few of the essential tumor cells.

The growth of a tumor may be rapid or slow, continuous or intermittent. A tumor may remain quiescent for months or years and suddenly take on rapid growth without any apparent cause. Rapid growth of a tumor is due to rapid cell formation, and is especially seen in those tumors in which cells and not intercellular substance form the chief constituents. Where a growing tumor comes in contact with the adjoining tissue the latter always suffers. Any tissue, be it the most resistant in the body, gives way before it. In part it may simply be compressed or pushed aside. The cells are destroyed in part by the effect of the pressure upon them, in part by the interference with their nutrition which the increased tissue pressure brings about, the compressed intercellular substance forming a capsule around the tumor, united with it by blood vessels and their accompanying connective tissue. A slowly growing tumor may produce great deformity of the surrounding tissue without destruction.

The slower the growth the greater the deformity which will be produced. Liver cells may be flattened out into long spindles around slow metastatic nodules, and I have seen the spinal cord compressed into a flat ribbon-like mass by the constant pressure exerted by a tumor of the dura. In other cases the tissue gives way without showing evidences of pressure. Cells and tissue may simply disappear when the growing tumor comes in contact with them. Occasionally the tumor cells are phagocytic, and surround and devour the tissue cells; in other cases the tissue cells seem to dissolve by contact with tumor cells. In the normal growth of bone the old bone is constantly removed by the action of large cells termed osteoclasts, which act in the same way as do the giant cells around foreign bodies. Where a rapidly grow-

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ing cellular tumor comes in contact with bone this may be removed by the tumor cells acting as osteoclasts. The tumor cells are able to make stronger demands on the nutritive material which is present, and in addition their presence and contact has in some unknown way a pernicious influence on the normal tissue. The growth of the mass of a tumor is in the direction of the least resistance. In consequence of this a tumor seated near a surface of the body projects above this and is often connected with the body by a pedicle. The best examples of this are given by the tumors with expansive growth as the myomata of the uterus which may form either submucous or subserous tumors connected with the uterus by a small pedicle.

Around a tumor which grows by infiltration it is not uncommon to find smaller and larger nodules apparently not connected with the main mass. Careful examination will show in many of these cases that the separation is not complete, but there is a strand of tumor tissue forming the connection. In other cases the separation is complete. These secondary masses are due to the extension of the growth along tissue spaces which offer little resistance, and when a locality favorable to greater expansion is reached a nodule is produced. Growth and tissue infiltration then proceed in the secondary nodules in the same manner as in the primary.

Under metastases we understand the secondary nodules which appear in different parts of the body and which have no connection with the main and primary tumor. These may appear in the most different organs, either singly or in hundreds or thousands, and may vary in size from a pin's head to several pounds. The metastases may be much more conspicuous and larger than the primary tumor. The metastases really represent a part of the primary tumor, and are due to cells and portions of tissue which have become separated from this and in various ways transported to different parts of the body where, being part and parcel of the primary growth, they grow with all of the characteristics of this. The conditions which they find in new regions may be so favorable that the primary nodule may be far surpassed in size. Single cells may by means of their own ameboid activity

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crawl along the tissue spaces and lymphatics often in a direction contrary to the course of the lymph stream and become the founders of new growths. Their progression is, however, much more frequently passive; they enter into the blood or lymph streams and they are carried in the direction of current until they reach narrow spaces, such as capillaries and lymph reticulum through which they cannot pass. The most extensive metastasis is by means of the blood vessels. The cells find their way into the blood either by growing into the vessels or from the lymph by means of the thoracic duct. Most frequently the cells are carried into the capillaries, but larger portions, which may be separated when the primary tumor invades large vessels, not infrequently lodge as emboli in arteries of greater or less size. The metastatic growth may then be associated with the circulatory disturbance resulting from the arterial occlusion. Where the cells lodge and the metastatic nodules form depends upon a number of conditions which are only in part physical. The entry into the blood is most apt to take place in veins, and hence the most frequent metastases in blood infection is in the lungs, the cells finding here the first capillary territory. The width of the capillaries is also of influence, those of the lungs being so wide that cells of considerable size may pass through them. The blood metastases in tumors of the alimentary tract takes place from the cells being carried by the portal veins into the liver, which offers by its numerous capillaries in which the circulation is slow favorable conditions for the lodgment of foreign substances. The most abundant metastases by means of the blood are found in the sarcomas which from the close relation of the tumor tissue to the blood vessels give favorable conditions for the entry of cells into the blood. The metastases will be the more abundant the smaller the tumor cells and the greater their energy and growth. We may find cases of sarcoma in which these conditions are fulfilled in which there are countless numbers of metastases appearing in every organ of the body. In one such case at the autopsy numbers of tumor cells were found in the circulating blood. The comparative freedom of certain organs in the body from blood metastases cannot be explained solely

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by the varying conditions of the circulation. Metastases are comparatively rare in the ovary, the uterus, and the brain, all organs which from the large blood supply and the abundance of capillaries should be favorable for the lodgment of cells. It must be said, however, that metastases in the liver and lung are easily recognized by their variation in color and consistency, and we should not compare the frequency of metastases in the ovary and testicles with that of the entire liver or lung but with equally large areas of these organs. It must be remembered that not only must the cells effect a lodgment, but they must find in the foreign situations favorable conditions for their growth.

Metastases by means of the lymphatics is, on the whole, more common than by the blood. Especially in the carcinomas the cells from the beginning are not only in close relation with the lymphatic system, but actually within it. The epithelial cells of a carcinoma penetrating the connective tissue as they do must enter into the tissue spaces, and by means of these into the lymph vessels. Even if we accept the prevalent view that the system of lymphatic vessels is a closed system similar to that of the blood vessels, the relation of the lymph vessels to the tissue is certainly closer than is that of the blood vessels, and cells from the tissue can more easily enter into them. It is rare, for instance, that we find a carcinoma of the breast in which a careful search will not show metastasis in the axillary lymph nodes, and I have repeatedly found carcinoma cells in the lymph vessels apparently on the way to the nodes. Secondary nodules are also formed by a process termed "implantation." This takes place when the primary tumor extends to a surface and cells or portions of tumor tissue become separated and attach themselves to other parts of the surface. This is especially seen in tumors of the ovary which extend to the peritoneum. In such cases the peritoneal surface may be literally sown with small tumors which have arisen in this way. Similar implantation may take place, though more rarely, in the case of tumors growing on mucous surfaces.

The metastases give us a further example of the marvelous capacity of the tumor cell for growth. When tumor cells are

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carried to a different part of the body they will grow in their foreign surroundings. In this they are sharply distinguished from the other cells of the body. There have been many experiments made to imitate the metastases of tumors by transferring normal tissue to different parts of the body. Entire organs may certainly be transplanted, and if they form sufficient vascular connections they will grow and function in their new situation. Cells, however, when separated from organic connection with the organs and placed in different situations, may, for a time, show some capacity for growth, but they finally atrophy and disappear. The result is the same whether adult or fetal tissues be chosen for the experiment.

One of the unfortunate conditions met with, particularly in the malignant infiltrating tumors, is a tendency to return in the same place after operation. It is now generally believed that this return of the tumor is due to the incompleteness of removal, and as we have learned more about the mode of growth of tumors and applied that knowledge to surgical operations, return is less often seen than formerly. In an infiltrating tumor, as a carcinoma of the breast, there is no certain means of telling at the operating table how far into the surrounding tissue the tumor extends. Not only must the tumor be removed, but all the lymph vessels which may possibly contain cells of the tumor on the way to the nodes must be removed. The operator must fully appreciate the fact that the cells of the tumor represent really infectious particles, any one of which remaining in the tissue may lead to a return of the tumor. It is self-evident that at the operation the tumor must not be cut into and the cells scattered. The idea is also held that the return of the tumor is not necessarily due to presence of some of the initial tumor cells, but the tissue in which the tumor primarily arose may retain a capacity for tumor development which may lead to the formation of a tumor similar to that removed.

The division of tumors into those which are benign and those which are malignant serves a more or less useful purpose. Strictly speaking, no tumor is benign. The situation of a tumor may be the criterion of its danger to the individual. A simple

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fibroma, so situated that by its growth organs essential to life may be compressed and their function interfered with, may involve greater danger for the individual than would a rapidly growing carcinoma in a less important situation. The characteristics of a malignant tumor, apart from the situation, are rapidity of growth, a tendency to invade surrounding tissues, to produce metastases and to cause a condition of general malnutrition in the bearer. The benign tumors are circumscribed, their growth is slow and expansive, they can be successfully removed, and do not produce metastases. The clinical importance of a tumor can usually be determined on microscopic examination. Rapidity of growth is shown by the number of nuclear figures indicative of cell division which are present. As a rule, those tumors which show an excess of cells compared with the intercellular substance have more malignity, but there are many exceptions. As a rule, also, the more the structure of a tumor departs from the normal structure, the more atypical it is, the greater the malignity. This is well shown in the carcinoma, as compared with the adenoma. Both tumors arise from the epithelium, and this constitutes the essential element in their structure. In the carcinoma the epithelium forms solid masses and strands, the cells having no definite relation to each other and the whole structure of the tumor has no analogy with the normal epithelial structures. The cells have lost all function, and even their capacity for orderly form and arrangement, retaining only the characteristic of growth. Between the masses of cells there is connective tissue which does not form an integral part of the tumor, and whose chief function is to bear the blood vessels for the nutrition of the epithelial masses. Neither blood vessels nor connective tissue penetrate within the epithelial cell masses. In the adenoma the separation into epithelial cell masses and stroma is as pronounced as in the carcinoma, but the epithelial cells do not grow in an atypical disorderly manner, but have the same definite relations to one another which they have in a gland. They retain to a certain degree, at least, the characteristics of their type. Owing to this typical arrangement, there is less tendency for the cells to be separated from their connections and invade or be carried into

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the surrounding tissue. In certain situations, however, as in the alimentary canal, the adenoma may be fully as malignant a tumor as the pure carcinoma. The same departure from the normal type is seen in the sarcoma as compared with the fibroma; although arising from the same tissue as the fibroma, it is atypical in being composed of cells with little or no intercellular substance. In the fibroma the cells retain their physiological property of forming intercellular substance.

That condition of general malnutrition termed "cachexia," which is so often found in the bearers of malignant tumors, cannot be explained by any single factor. It is true that the tumor cells make a stronger demand on the nutritive forces than can the normal tissues, but the withdrawal of nutrition alone cannot account for the cachexia. With the rapid cell growth of malignant tumors there is constant degeneration and absorption, and such products of degeneration have a toxic action on the body. There is also in many cases the accompaniment of intense pain due to the pressure of the growing tumor on sensory nerves, producing sleeplessness and anxiety. The greatest degree of cachexia may be observed in cases where, with these conditions, there is interference with the nutrition of the body due to the situation of the tumor, as when constriction of the alimentary canal is produced.

The study of the regeneration of tissues has shown us that like tissue comes from like. Epithelium only develops from epithelium, blood vessels only from blood vessels, etc. The formation of unlike tissue is termed metaplasia, and tissues nearly related can be formed from one another. Thus it is impossible for the several simple forms of epithelium to be transformed into one another, as when the interior of the uterus becomes covered with squamous epithelium, or when islands of squamous epithelium are formed in the trachea. The various forms of connective tissue can be formed from one another. In chronic inflammatory conditions both cartilage and bone can be formed in connective tissue at a distance from normally situated cartilage and bone. Tissues wholly unlike, representing a wide differentiation, cannot pass into one another. The same holds true

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for the tumors. A tumor representing a definite tissue is only formed from such tissue, an epithelium tumor arises only from connective tissue. This holds good even for the differentiated epithelial structures. A tumor of the squamous epithelial type only arises from squamous epithelial, a cylindrical cell cercinoma only from a surface covered with cylindrical epithelium, a glioma only from pre-existing neuroglia. But there seem to be many exceptions to this rule. There are certain tumors which differ in all respects from the tissue from which they apparently spring. It is not uncommon to find a tumor in the kidney surrounded by kidney substance and apparently springing from this, which repeats the structure of the adrenal gland. In the same way tumors of the parotid may contain epithelium very unlike the epithelium of this gland, and in addition cartilage and other structures. In tumors originating in the genital glands we may find among a variety of tissues highly differentiated epithelial structures. Then tumors are to be explained in two ways. They either develop from cells such as the germinal cells, male or female, which in themselves carry the capacity of forming the further differentiated tissue, or they develop from portions of embryonic tissue which have in the course of development become separated from their organic connections and hence do not undergo further development. These tumors of complex structure are termed "teratomas" from the analogy which they show to the malformations, or embryomas from the similarity of their tissue to that of the embryo. As we shall see later, this theory of embryonic inclusions plays an important part in the etiology of tumors.

Of the cause of tumor formation our knowledge is most deficient. The theories which have been advanced, and in many cases defended with great ingenuity, may be considered under three heads. First, the traumatic theory, which assumes that a tumor forms in consequence of an injury to a part. It is probable that this theory has a wider acceptance than any other. It is based largely on statistical evidence. A person presenting a tumor is asked in regard to an antecedent injury. The character of the injury and the length of time which has elapsed between its receipt and the appearance of the tumor is little con-

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sidered. There is a tendency always to connect a present with some antecedent event, and careful inquiry can usually elicit a history of injury which would have been otherwise forgotten. The tendency to refer a tumor to an injury seems to me very much like the widespread belief of the laity that a malformation may be due to some event which has produced a mental impression on the mother. The examples most usually cited as evidence of the relation between tumor and trauma are the carcimona of the lower lip in man, supposed from the habit of smoking, and carcinoma of the scrotum which develops in chimney sweepers as a result of the constant irritation produced by the soot. It is perfectly true that the carcinoma of the lower lip is much more common in men than in women and that the habit of smoking is more prevalent in men. But the traumatic theory does not explain why the tumor develops chiefly on the lower lip. Carcinoma of the cheek is, if anything, more common in women than in men, notwithstanding the more frequent injuries produced by the shaving habit. Epithelial tumors do not appear on those portions of the surface of the body which are most subject to injury. The epithelial carcinoma is comparatively rare on the hands, and almost unknown on the feet. Carcinoma of the rectum does not appear, as a rule, immediately at the anus, where we might suppose that injury and irritation would be greatest, but higher up in the gut and at the point where the squamous epithelium of the skin joins the cylindrical epithelium of the alimentary canal. It has been held that a trauma may act in two ways in producing a tumor. In one theory the cells may be excited to proliferation and this may continue, finally leading to the production of a tumor. The matter of cell proliferation is not as simple as it appears on first sight to be, and is only one of the phenomena which the tumor presents. The surest way to produce a proliferation of cells is by an injury. Depending upon the character of the injury there may be a great difference in the degree and the character of the proliferation. The action of certain bacteria is characterized by the formation of new cells in their vicinity, and the new tissue produced may be so characteristic that we can determine from it the causative agent, as in the case of tuber-

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cle and leprosy bacilli. In other cases around a simple injury a tissue is produced which differs from the normal tissue of the part in the abundance and character of the cells, which extends considerably beyond the territory immediately injured and which has a certain similarity to the tissue of certain tumors. Certain toxic substances, particularly bacterial products, excite proliferation in tissues apparently not affected by the direct injurious action of the agent. One of the most striking examples of proliferation is seen in the lymph nodes in the vicinity of the vaccination area in vaccinia. The typhoid toxin has a remarkable influence in producing proliferation of the endothelial cells, particularly in the lymph nodes and spleen. Other agents may excite to proliferation the peritoneal epithelium or the cells lining the capillaries of the glomeruli of the kidneys. All of these examples, however, whether acting locally to the injury or at a distance, can only be regarded as in the category of regeneration. The injurious substance, whatever its nature, affects the interrelation of cells or systems of cells with each other and with the organism as a whole and proliferation takes places until the normal balance is restored. In certain cases, as between the epithelium and the connective tissue, one tissue seems to hold the other in check. In case of continued impairment of the connective tissue, one tissue seems to hold the other in check. In case of continued impairment of the connective tissue, the epithelium, where it comes in contact with such tissue, has the power of invading it and growing as in an epidermoid carcinoma. As soon as the limit of the injured tissue is reached the epithelial growth ceases. All of these examples are far removed from analogy with tumors. The new tissue does not continue to grow as a parasite and independently; it ceases when the integrity of the organism is restored and when the action of the agent producing the injury is removed.

In the second place, it is held that the injury may lead to tumor formation, in that by means of it cells are separated from their organic connection with the tissue to which they belong, and that such separated cells may assume independent characters and become the origin of tumors. Ribbert was formerly inclined to

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assign to such separation and displacement of tissue an important role in the production of tumors. There is no experimental evidence for such view. Tissues so displaced either after remaining a time are absorbed and disappear or they become permanent and grow as in their old situation. There have been a great number of such experiments in which both adult and fetal tissues have ben separated from their normal connections and implanted in other parts. Embryonic and fetal tissues so displaced show a greater activity of growth than adult tissue, but finally are, like these, absorbed and disappear. In considering the effect of trauma in the production of tumors the very numerous experiments which have been made on man are usually left out of consideration. I allude to effects of surgical operations. In these the most varied injuries are produced. In most cases in addition to the acute injury involved in the incisions there is combined the chronic injury and irritation of the sutures. Moreover, the most ideal displacements of tissue are produced. Cells and tissues in greater or smaller masses are separated and included in foreign tissue. It is probable that in every suture placed in the skin epithelial cells are dragged into the subcutaneous tissue, and this is more particularly the case in intestinal surgery. Yet I have never heard of an instance in which a tumor, with the possible exception of a keloid, appeared in the site of a suture after a surgical operation. Most surgeons, I think, hold with greater or less tenacity to the traumatic theory of tumor formation, and yet the thought of the possibility of a tumor following their traumas dos not enter into their calculation. In any consideration of the traumatic theory, it must be remembered that tumors of various sorts are quite common pathological conditions, that traumas are also common and that combinations of the two incidents might be frequent and striking. The theory lacks all experimental confirmation, and, as it stands at present, it has much the same footing as does the theory of maternal impressions as a cause of malformation. In both there are many striking coincidences.

Another theory which has had many defenders in the past two decades, though less now than formerly, is that of living para-

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sites being the cause of tumors. In the first place, an analogy was sought between certain of the infectious diseases, especially tuberculosis, and the malignant tumors. At first sight the analogy seems striking. In both there is a characteristic tissue produced, and a primary focus from which the disease extends, the extension taking place by means of the blood and lymphatics. There is, however, this striking difference: In the case of the tubercle there is an agent, the tubercle bacillus, which is carried to various places and excites proliferation in the various tissues leading to the formation of the tubercle. In the malignant tumor it is the tumor cell which is carried from place to place, and this does not excite proliferation, but itself proliferates. The cancer cell has its analogy not with the tissue which is produced by the bacillus, but with the bacillus. The part which the tissue plays is to act as a host, in greater or less degree hospitable to the invader. The tissue reaction which is often seen around a tumor metastasis is the analogue with the tubercle. That it is the tumor cell to which the metastasis is due is an easly observed fact. In favorable cases it is possible to follow the formation of a metastatic nodule from a single cell, and isolated cells are often found in the lymphatics and blood vessels on their way to lodgement and metastasis production.

Support was found for the bacteria theory in the fact that cultures made from tumors often showed the presence of bacteria. It was soon found, however, that these bacteria were not specific, that they were found chiefly in tumors to which bacteria had access by ulceration and that they represented nothing more than common, invading wound bacteria. As we have become better acquainted with the different classes of infectious agents, each class in turn has undergone the odium of accusation as the etiological agent of tumors.

Following the bacteria the blastomycetes had their turn. They were not only found in tumors as were the bacteria, but tumors were said to be produced by the injection of pure cultures into animals. Certain of these organisms are infectious for animals; they find in their tissues conditions favorable to their growth and produce circumscribed nodules varying in size which to the

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naked eye greatly resemble tumor metastases. As in the tubercle, histological examination shows that the nodule is composed of actively multiplying organisms and cells coming from the tissue.

The protozoa seemed to offer a still more favorable field for etiological quest. Many of these are intracellular parasites, and in the course of their cyclic development they assume a variety of forms within the cell. No infectious agent produces a lesion which seems to have such an analogy with the tumor as in the coccidial disease in the rabbit's liver. The organism here enters the epithelial cells of the bile ducts. These cells proliferate with great rapidity, papillary ingrowths into the ducts are formed and circumscribed nodules aret produced which have, both to the eye and microscopically, a striking similarity to papillary and intracanalicular papillomata. But the cells of the nodule are not infectious; they are produced by the action of the coccidium, and apart from this organism they have no independence. The striking morphological changes which are produced in the development cycle of the coccidia also led to the belief that certain small bodies, often found included in tumor cells, chiefly in carcinomas, were forms in the development cycle of some protozoan. As knowledge of the protozoa increased and better technical methods for their study were developed this has appeared always more improbable. There are undoubtedly certain microscopic things often found included within tumor cells the nature of which we do not know. Their character probably varies; some of them show similarity in form and size and seem of the same character, but others vary in all respects. Nothing approaching a protozoal cycle has been made out, and the inclusions are best explained as products of cell and nuclear degeneration, or products resulting from inclusion of other cells, or products of cell secretion.

And finally the spirocheta have had their turn. They have been described in the transferable tumors of mice, and in turn shown to be a common reinfecting organism in the mouse, and their occasional presence of bacteria. Further support of the infectious theory was given by the discovery that the tumors of certain animals are inoculable. Carcinomata of mice are inocu-

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lable and a few other tumors, both carcinomas and sarcomas, have been found in rats which were capable of transmission. In the ordinary inoculation procedure small pieces of tumor are rubbed up into an emulsion which is injected beneath the skin, or a small piece of tumor tissue is placed in an incision beneath the skin. But this has been shown to be very different from the transmission of an infectious disease. The infectious disease is transmitted by transferring to the inoculated animal the cause, and this growing in the tissue produces the lesions by its reactions on the tissue. In the transference of the tumor, the tumor cells grow in the inoculated animal just as they would grow in a metastasis. It is here again the tumor cell which has the capacity of a parasite, and not an inoculation of an infectious agent, which causes the tumor cell to form. The only parasite it would be possible to conceive of would be one living within the cell and transferred with the cell. The defenders of the parasitic theory seem to have had in mind only tumors of the carcinoma type.

But all tumors have so much in common that any cause must be equally applicable. Moreover; there must be a different cause for every tumor, certainly our knowledge of infectious diseases forbids us to believe that the same parasite can in one instance produce a carcinoma, in another a fibroma, and in another a teratoma. The parasitic theory could give us no explanation whatever of the congenital tumors. Take the example of a congenital tumor of the kidney, in which the tissue more closely resembles the Wolffian body than it does any adult tissue, or the congenital tumors of the retina in which there are embryonic neural structures, or the glioma of the coccyx in which neuroglia is found far removed from its normal situation, and it is impossible to think of an infectious agent producing such formations.

Some analogy has even been sought in the comparison of the infectious nodular growths in plants with true tumors. These, however, are not tumors except in the sense that the coccidial nodule in a rabbit's liver is a tumor. Again, tumors seem to be more common in those organs of the body which are most secure from their structure and situation from ordinary infections. Apart from the accidents which may happen in pregnancy

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and lactation there are few infections which have their seat either in the uterus or in the mamma. It would be useless to go on enumerating the arguments against infection by living organisms being considered a cause of tumors. Every theoretical consideration is against the theory and not one proven fact has been shown as a substantiation of the theory. It is, however, interesting to see how stimulating to knowledge an hypothesis even with so little in its favor may be. It was brought forward at a time when the limits of pure anatomical research on the subject by the methods then in use seemed to be exhausted. It served to stimulate the imagination and to again turn the attention of able investigators to renewed research, and the most important of the knowledge we have on tumors may be traced to the influence of the hypothesis. The literature on the subject, both pro and can, has reached an extent that it is almost impossible for one to control it. It would be absurd to say that the hypothesis cannot be true, but if an infectious living organism be found, which will produce a growth having all the characteristics of a true tumor it must be an organism of a different class, and act in a way at variance with all we know of the action of infectious organisms.

The third theory of tumor formation is that known as the embryonic or germinal theory. This theory has so far held its ground much better than either the traumatic or the infectious theory. Although not original with Cohnheim it was advanced and defended by him with so much vigor as to have become known as the Cohnheim theory. Briefly stated, this theory assumes that in the course of embryonic development, certain of the tissues do not undergo perfect development but remain in an imperfectly developed or embryonic condition and are included within the developed tissues. It is assumed, further, that in the course of embryonic development in the opposing intergrowth of tissues, and in the complexities of tissue formation which then take place, such separation of embryonic tissue easily takes place. Such separated tissues will then be abnormally situated or included in other parts, and may go on to complete anatomical or functional development as is seen in the accessory

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spleen, adrenal gland, and pancreas, or they may remain undeveloped or imperfectly developed. Such tissue withdrawn from the influences of the inter-relations of parts would be capable of life as independent of the organism as a whole as a parasite would be. The cells would retain the embryonic capacity of growth and be free from the restrictions of growth which are imposed upon tissues by their relations with each other and with the body as a whole. This theory brings the subject of tumors in close accord with the malformations, in thus referring them to an embryonic origin. This theory accords best with what we know of tumors, and so far as I know there is nothing incompatible with it. It is perfectly certain that in embryonic development such separations of tissue not infrequently take place, and also certain that tumors do develop from such separated parts. Thus we may find portions of fully developed adrenal tissue included either in the capsule or in the cortex of the kidney, and we also not uncommonly find tumors in this situation which have the characteristics not of the kidney but of the adrenal gland. Even tumors which are seemingly of glandular origin often do not arise in the substance of glands but in tissue adjacent to but not connected with the gland. A great many examples might be cited as evidence that tumors frequently originate in such misplaced tissues, but the theory does not give a complete explanation. It does not explain the growth; it does not show why these misplaced tissues develop into tumors; why the development is associated with certain periods of life; why it is not possible to produce tumors by the artificial inclusion of embryonic tissue; why the inoculation of tumors succeeds only in certain animals. To this hypothesis as to the origin of tumors which seems to have so much in its favor there must be added another as to cause. We must assume that at a certain period these germinal remains gain a power which enables unrestricted growth to take place, or what amounts to the same thing, the other tissues lose their power of restraining and regulating growth. It would be impossible in the limits of this paper to enter into a consideration of this part of the subject.

Nor will it be possible for me to take up the subject of the ex-

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perimental study of tumors which is being actively prosecuted in a number of laboratories and by men well qualified for research. It is from such experimental study in which all of the conditions can be controlled that we have most to hope. The subject of tumors is, further, one of general biological interest and should be attacked by the embryologists and zoologists who bring to the investigation both new methods and new points of view.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

Unilateral Nephritis; Nephrectomy.

Angerer (*Archiv f. klin. Chirurgie,* lxxxi, 2) reports two cases of unilateral nephritis resulting from traumatism of the loin. No renal symptoms appeared at the time of the injury, but showed themselves several weeks afterwards. The trouble began with colicky pains in the kidney, accompanied with hematuria. The urine showed albumin and casts, and the general health was profoundly influenced. In one case the operation of nephrectomy was undertaken on account of the hematuria, and in the other the severity of the pains brought the patient to operation. Recovery was perfect in both cases, and all signs of renal disease disappeared completely. In both cases the kidney was large, congested, with hemorrhagic areas in the cortex. The author believes the operation was indicated, and was justifiable, as each case recovered promptly. He believes nephrectomy would have been dangerous, on account of the liability to post-operative hemorrhage. —*The Lancet Clinic.*

The Syphilis of Decent Women.

This recently formed the subject of a communication made to the *Academie de Medecine* by Prof. Edmond Fournier. He stated that in his city practice he had observed the proportion of syphilitic women who were decent was not less than one-fifth of the entire number. The contamination is the result at one time of a syphilis contracted by the husband before marriage, at other times from a syphilis contracted during the married state. The second variety is more unusual and represents but one-third of the total number of cases. The infection is sometimes very soon, 20 days after marriage in one case, or it may be late, the seventh year. But in the large majority of cases the infection takes place in the first year of married life. And, almost always, questioning

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revealed the fact that the husband at the time of marriage had a syphilis of recent date, going back less than three years. At times even (and this fact has a great importance in regard to medical authority to marry) the syphilis is older. If it goes back four or five years it would appear more desirable. It is perhaps nothing more than a minimum period. In other cases infection is inevitable and forced. Sometimes the marriage takes place whilst the husband has syphilis in the stage of incubation. In such a case, if the latter has become contaminated in his last efforts to bury his bachelorhood, that is, shortly before his marriage, and the first symptoms develop insidiously, the husband looks upon them as a chafe, a herpetic vesicle, or some insignificant sore, and does not bother about it. Others are cynical and determined to get married because it is a good thing; and others are careless and do not care.—*Maryland Medical Journal.*

PICROTOXIN AS A PREVENTIVE OF POST-CHLOROFORM SICKNESS.

In *The Lancet* for September 14, 1907, P. Paterson refers to the use of picrotoxin as a preventive of the vomiting which often follows chloroform or chloroform-ether anesthesia. The author notes the difficulty of determining the true value of any remedy under these circumstances, because some patients never vomit at all, but he claims that a comparison of a series of cases in which picrotoxin has been given with a series in which it has not, shows a marked difference. The difference has been especially emphasized in those cases in which an anesthetic having been given several times, violent vomiting was absent only when the drug named had been administered. It must be given as soon as the anesthetic is withdrawn. The author employs a 0.2 per cent solution in sterile water, and injects 20 minims (adult dose) of this solution into the subcutaneous tissues. For a child of four years 5 minims suffices. If, as rarely happens, sickness appears and lasts ten minutes, a second injection half as large as the first is given. The author is so convinced of the efficacy of picrotoxin under the conditions named that he employs it as a routine measure in all of his chloroform cases.—*Medical Record.*

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Extirpation of a Popliteal Aneurism.

Lediar operated by a six-inch incision over the popliteal space, dissecting out the artery above and below the aneurism and dividing it between double ligatures. It was then dissected away without difficulty, except where the sac was adherent to the popliteal vein. Finally the vein was divided. Cramp in the calf and a burning feeling in the foot followed, but disappeared in a few days. In a little over three months the patient was able to kneel slowly without pain, and to walk with only a slight limp. About four months later he was able to walk three or four miles without trouble and without a stick, and was engaged as a gardener. Lediard considers the question of extirpation of aneurisms generally, and thinks that there is good reason for having recourse to extirpation in all aneurisms in accessible positions.—*Journal of the Medical Association.*

MEDICAL

Is the Gallbladder a Useless Organ?

Thanks to the development of surgical methods, we have learned that there is quite a number of abdominal organs with which, it would appear, one can dispense, especially when diseased. The most familiar instance is the appendix vermiformis, that alleged useless relic of a lower stage of evolution which plays so important a part in abdominal pathology. We know that large portions of the intestine may be resected without deleterious consequences; that the entire stomach may be removed without marked resulting discomfort, and that spleenless persons get along fairly well. Most of our patients, however, prefer to retain as much of their anatomy as possible, and we should not be ready to consider an organ as useless because we are ignorant of its function. It is, of course, sound policy to remove any portion of the body that appears hopelessly diseased, but should this be questionable, then its alleged uselessness should not necessarily constitute an argument in favor of it removal.

We cannot, therefore, approve of the growing tendency on the

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part of some surgeons to remove the gallbladder in nearly all cases of disease of this organ on the ground that its functions are of little importance. In the discussion on cholecystectomy at the last meeting of the British Medical Association, Mr. J. Bland-Sutton, in his argument in favor of this operation, made the assertion that the bile was purely an excrementitious fluid. It seems to us that this is merely a theoretical assumption. The physiological investigations of Herter and others have shown that the bile acids play an important part in intestinal digestion, assisting in the saponification of the fats, promoting peristalsis, and preventing putrefactive processes in the bowel. It is for this reason that under normal conditions the bile is especially poured out at the time of digestion, and that the gallbladder acts as a storehouse in the interval. A person deprived of his gallbladder is therefore more liable to suffer from digestive disturbances than one in whom it still exercises its functions as a reservoir. A number of surgeons in the discussion expressed themselves strongly against a routine excision. There are, of course, certain conditions, such as severe and, especially, suppurative cholecystitis or malignant disease, which make cholecystectomy imperative, but its general substitution for simpler and less radical methods is to be deprecated.—*International Journal of Surgery.*

Calcium Chloride in Hemorrhage.

Dr. A. Stanley Green (*Brit. Med. Journal,* May 4) thinks that the value of calcium chloride seems to be very much underestimated in cases of hemorrhage. During the past eight years he has had some very striking results. He claims that the action of the drug is rapid, if given in sufficiently large doses, and reports having been called in the middle of the night to see a medical man who was suffering from hemorrhage after the removal of two lower molars, and who had tried all the remedies he could think of before sending for him. He was ordered to take 20 grains of calcium chloride every hour, and the next morning the patient remarked that the hemorrhage ceased after the third dose. Before doing an intranasal operation Dr. Green always insists upon the patient having full doses of this drug for three days, and since

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he has made this his rule he has never had any troublesome hemorrhage, nor has he had to plug a nose.—*Therapeutic Medicine.*

Adrenalin in Neuralgia, Neuritis, and Reflex or Referred Pain.

Adrenalin has been used by the writer externally to combat the pain accompanying functional neuralgias and neuritis. The only absolute failures noted were in cases of neuralgia springing from toxic conditions. Reflex neuralgias of great severity were relieved for periods varying from a few hours to several months, and the pains of gout, articular and muscular rheumatism, and myalgia are relieved almost entirely for a considerable time after the application of the adrenalin. In nearly 100 cases one application of an adrenalin ointment relieved the ptient of pain in cases of recurrent facial neuralgia for periods of from one month to six months. The writer says that the quantity of a 1 to 1000 ointment of adrenalin to be used in any affection of a peripheral nerve should not exceed from one to two minims, by inunction, except in case of the sciatic nerve, when two or three minims may be used. Larger quantities often produce ischæmia, which might prove injurious. The application of the ointment must be made directly over the affected nerve.—*H. G. Carleton* (*Therapeutic Gazette, May,* 1907.)

OBSTETRICAL

The Early Diagnosis of Tubal Pregnancy.

P. A. Harris says twenty-nine out of every thirty cases of ectopic pregnancy present symptoms warranting a presumptive diagnosis of the condition before it becomes alarming. He found, however, from a study of 130 cases, that while ninety per cent of the patients consulted physicians before the tragic state was reached, only about twenty per cent of the physicians arrived at a correct presumptive diagnosis, and many of the patients were wrongly advised of threatened abortion, or were subjected to

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curetting for metrorrhagia, the cause of which was not suspected. The general answer he has given when asked how to diagnose ectopic pregnancy is as follows: "When any woman after puberty and before the menopause, who has menstruated regularly and painlessly, goes 4, , 6, 8, 10, 15, or 18 days over the time at which menstruation is due, sees blood in the vagina differing in quality, color, quantity or continuance from her usual menstrual flow, and has pains, generally severe, on one side of the pelvis or the other, or possibly in the hypogastric region, ectopic gestation may be presumed." The blood of the ectopic pregnancy hemorrhages has a peculiarly slippery feel, and the pains also differ markedly from those of ordinary dysmenorrhea. The pulse and temperature, except in cases of excessive bleeding, are not likely to be affected in the non-tragic stage. The tragic stage is ushered in by severer pains, pallor, weak and rapid pulse, lowered temperature, fainting, generally vomiting and restlessness, and sometimes a lethargic condition from which the patient can be roused. The findings of the physical examination and the differential diagnosis from abortion, salpingitis, uterine cancer, ovarian cyst with twisted pedicle, and intrauterine pregnancy with metrorrhagia are detailed, and six case histories are given. In his concluding remarks Harris insists on the importance of thorough and accurate history taking in these cases, especially as to the character of earlier menstruations for a number of months preceding the symptoms. As soon as diagnosis is made, operation is indicated. In dealing with women in the non-tragic stage, the advice to them should be governed by the consideration that from one-half to two-thirds of all cases of ectopic gestation, uninfluenced by operation, eventuate in death, but that with prompt and proper operation ninetynine per cent of the patients ought to recover.—*Medical Record.*

Treatment of Tubal Abortion.

Professor Doederlin (Medical Society of Tubingen) states that the most frequent form of ectopic pregnancy is the tubal, and that this condition is much more common than was formerly assumed, since it has been found in many cases in which other diseases

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had been previously diagnosed. In a typical case of tubal gestation there is early death of the embryo with the secondary formation of a mole and intraperitoneal hemorrhage. This is much more likely to occur than tubal rupture with a living fetus or continuation of the pregnancy. It is important, however, to bear in mind that the death to the embryo does not terminate the pathological condition, but rather that it is the beginning of untoward sequelæ. Changes occur in the embryo which are accompanied by more or less profuse bloody effusions into the abdominal cavity. With reference to the treatment of tubal pregnancy Doederlein's experience, based upon 135 cases, leads him to believe that an expectant plan is no less free from risk than operative measures. Among twenty-four cases treated expectantly there was a mortality of 8 per cent, death resulting from severe intraperitoneal hemorrhage, while of 111 women treated by operation only four died.—*International Journal of Surgery.*

Treatment of Inoperable Uterine Cancer.

M. Heinkel (*Zeitschr f. Gynecol. u. Geburt.*, Vol. lix, part 3) advises against the uniform employment of but one operative method of operation in the treatment of uterine cancer. If the cancer is limited to the uterus, or if the parametral infiltration does not extend to the pelvic wall, he advises a radical vaginal removal with the aid of the cautery. Every extensive infiltration of the pelvic cellular tissue necessitates an abdominal operation for complete removal.

Any recurrences should be operated upon if possible, and of course as soon as discovered. For this purpose every patient operated on for cancer should report for examination every ten to fourteen days.

For inoperable cancer, the use of the Paquelin cautery is recommended. Such a cauteriation should be done at frequent intervals.—*St. Louis Medical Review.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

THE PROPOSED METHODIST HOSPITAL.

The establishment in this city of a magnificent Methodist Hospital is a subject of vital interest and importance to the profession, not only of Nashville, but of the State at large, and the entire South. The accomplishment of this enterprise appears to be an assured fact, and the movement has already been placed upon a firm footing by the formation of a Board of Managers, and the purchase of a suitable piece of property as site of the building. The prospects of erecting an institution, at a cost of over $300,000 are at present very bright, and we look to see the fruition of this promise in the near future. The advantages of such a hospital are manifold—the people, the medical colleges and business interests all being the beneficiaries. The work is on in earnest, and we hope ere long to see in course of successful operation a Protestant hospital, the doors of which will be open to the sick of all religious denominations. We would prefer that the work of establishment should be done equally by all denominations, making it, broadly speaking, a Protestant hospital, but since the powerful Methodist church has taken the initiative, let the honor rest there, and let other denominations, without jealousy or prejudice, join in the good work. We certainly commend the enterprise, and wish it every success. In this connection we are glad to report the adoption at the meeting of the Tennessee Conference last week, in Springfield, Tenn., of the following report of the Board of Missions, which placed the stamp of approval upon the movement,

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and is an excellent earnest of the aid the enterprise will receive from this powerful source. The report is as follows:

"*Whereas,* The Gospel of Christ is for the whole man; and

"*Whereas,* Steps have been taken to establish a Methodist hospital in the city of Nashville, Tenn., on the broadest Christian basis; and

"*Whereas,* The Board of Managers for said institution has purchased a location and has secured a considerable amount in subscriptions for the same; therefore be it

"*Resolved,* That the Tennessee Conference, in session at Springfield, Tenn., does most heartily endorse this movement and agrees to give it the right-of-way over all other claims, the assessments for our regular work and any unredeemd pledges for special work excepted.

"A. T. KERLEY, *President.;*
"W. B. TAYLOR, *Secretary.*"

Among the addresses made upon this occasion, all of them earnest and enthusiastic, that of Dr. John A. Witherspoon, of this city, was a most powerful and convincing appeal, a presentment of the subject that was most effective and far-reaching. Undoubtedly this eloquent address made a powerful impression upon the members of the Conference. This gentleman stated in his address that the Medical Department of Vanderbilt University, at a meeting on October 16, had voted to subscribe $12,500 to the movement. We are gratified at the substantial progress that has been made along these lines, and shall report from time to time.

A joint session of the Medical Societies of Robertson County, Tenn.; and Todd and Logan Counties, Ky.; was held at Guthrie, Ky., October 1. An interesting programme had been prepared by the Todd County Society, and was carried out by Dr. Simmons reading a paper on Bright's Disease in Children; Dr. Frey, on Early Diagnosis and Treatment of Tuberculosis; Dr. Barker, on Cystitis; Dr. Willett, on Management and Treatment of Mastoiditis; Dr. Ramer, on Treatment of the various forms of headache. Each and every paper was freely discussed; Drs. Frey,

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Simmons and Tyler presented each an interesting clinical case.

Dr. J. M. Robinson very gracefully presided over the meeting. There were thirty-five physicians in attendance through the whole meeting.

NEED OF FORESTRY IN PRIVATE LUMBERING OPERATIONS.

"The fuller utilization of forest products which characterized the operations of lumbermen of 1906 marked the greatest gain of the year in private forestry," states the Yearbook of the Department of Agriculture. "Eminent success in systematic effort to prevent damage by fire was obtained by private owners,as well as by the States and the Federal Service. That forest preservation has come to be regarded as a matter of deep concern to every citizen is manifest. Private forestry has grown until not only are professional foresters employed regularly by a number of large firms, but firms of consulting and contracting foresters supervise cutting operations and guarantee to the owners renewals of the trees desired in the forest. Large users of forest products tend more and more to apply sound methods to the raising of wood crops and to their careful utilization.

"Too much wasteful exploitation has made heavy inroads in the forest which once stretched almost unbroken from the Atlantic to the prairies. In obedience to the law of supply and demand, lumber prices have gradually advanced in the past twenty years, in some cases as much as 108 per cent. These changes show that it is high time for the introduction of conservative forest methods in the management of woodlands everywhere. There are now a million acres of private woodland on which forestry is being applied under plans prepared during the past four years by the Forest Service; but this is only a beginning. The scope of this management must be increased many fold.

"To supplement and complete the statistics of forest products, there is great need for accurate knowledge of the standing timber in the country, and its stumpage value. Sizes and species are now used which formerly were left as unmerchantable, so that all former estimates are out of date. Any future estimate of timber should leave out of consideration the present merchantable value

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of timber, and should aim to show the actual stand of timber, regardless of size, species, or quality. The inadequacy of former estimates is shown by a single instance in which the coniferous cut since 1880 has exceeded by 80,000,000,000 feet the total estimated stumpage of those woods at that time. And this is not only because of the scarcity of better grades and larger sizes, but also because of the improvement of forest methods, largely brought about through the application of forestry.

"The nation can and should maintain forests in isolated and mountainous regions where their principal value is for the protection of watersheds, the sources of streams, and the many industries dependent upon an equable supply of water and a sufficient range. But on private lands the practice of forestry can be expected only where it insures profit in perpetuating a source of timber supply. Since four-fifths of the forests of the country, and, in general, those most productive and accessible,, are in the hands of private owners, the future timber supply rests chiefly with them. Timberland owners are realizing this fact. In the eastern part of the country, forests under management are now so numerous that some one of them can be visited for inspection by a few hours of railway travel from any point·

"At no previous time have the prospects for success in private forestry been so good. Depleted supply encourages conservative use, and increased knowledge of the less familiar forest trees, of improved methods of management, of seasoning and kiln-drying methods, and of markets, enables the lumberman or landowner to lay his plans with a confidence hitherto impossible.

"More and more is the entire tree being utilized, by cutting the trunk nearer the ground and higher into the crown; by the use of modern equipment which secures the minimum of waste at the mill; and, in the hardwood regions, by the construction of charcoal blast furnaces and chemical plants to utilize the bark, limbs, edgings, slabs, and even the sawdust, in the manufacture of charcoal, wood alcohol, and acetate of lime."

The article, "Progress of Forestry in 1906," illustrated, of which the above is an extract, has been issued, together with a directory of forest officers, associations, and schools, in pamphlet

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form. It can be had upon application to the Forester, Forest Service, Washington, D. C.

PRELIMINARY ANNOUNCEMENT OF THE NINTH ANNUAL MEETING OF THE OHIO VALLEY MEDICAL ASSOCIATION.

FIRST DAY, NOVEMBER 13, 1907—MORNING SESSION, 9:30 A. M.

I. Meeting called to order by chairman of Committee of Arrangements, and president introduced.

II. Address of Welcome, on behalf of the city, by Mayor J. W. Boehne.

III. Response, on behalf of the Association, by Dr. Dudley S. Reynolds, Louisville, Ky.

IV. Report of Committee of Arrangements.

V. Report of secretary and treasurer.

VI. Appointment of Committees.

A copy of all essays read before this Association is expected to be handed to the secretary, and will appear in its proceedings.

1. Diagnosis and Prognosis in Gastric Ulcer, by Dr. R. H. Moss, Niagara, Ky. Discussion opened by Dr. G. M. Young, Evansville, Ind.

2. Interstitial Nephritis, by Dr. D. O. Hancock, Henderson, Ky. Discussion opened by Dr. Chas. Knapp, Evansville, Ind.

3. Brain Tumors, with Specimens, by Dr. Herman H. Hoppe, Cincinnati, Ohio. Discussion opened by Dr. W. A. Quinn, Henderson, Ky.

4. When Baby is Born, by Dr. T. A. Frazier, Marion, Ky. Discussion opened by Dr. G. P. Hodson, Evansville, Ind.

5. Patent Medicines—Both Nostrums and Proprietary, by Dr. T. J. Shoemaker, Morganfield, Ky. Discussion opened by Dr. John Wyttenbach, Evansville, Ind.

6. Extra Uterine Pregnancy, with Report of Cases, by Dr. J.

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W. Hamilton, Mt. Vernon, Ind. Discussion opened by Dr. P. N. Hoover, Boonville, Ind.

Adjourn for lunch.

FIRST DAY—AFTERNOON SESSION.

Meeting called to order at 1:30 P. M.

7. Some Phases of the Tuberculosis Question, by Dr. C. W. Lillie, East St. Louis, Ill.

8. The Out Door Life, and Specific Treatment of Tuberculosis, by Dr. Paul Paquin, Asheville, N. C.

9. General Tuberculosis, by Dr. Benj. F. Lyle, Cincinnati, Ohio, Discussion opened by Dr. C. P. Bacon, Evansville, Ind.

10. Dislocated Kidney—Its Pathological Possibility, by Dr. Earl Harlan, Cincinnati, Ohio. Discussion opened by Dr. Arch Dixon, Henderson, Ky.

11. The Latest Verdict of Science on the Alcohol Question, by Dr. J. H. Kellogg, Battle Creek, Mch. Discussion opened by Dr. Dudley S. Reynolds, Louisville, Ky.

12. The Physician in His Civic Relations, by Dr. Chas. A. L. Reed, Cincinnati, Ohio. Discussion opened by Dr. J. N. McCormick, Bowling Green, Ky.

13. Painful Feet, by Dr. John L. Porter, Chicago, Ill. Discussion opened by Dr. H. D. Allen, Indianapolis, Ind.

14. Chronic Inflammatory Diseases of the Pelvic Connective Tissue, by Dr. Emil Ries, Chicago, Ill. Discussion opened by Dr. J. Garland Sherrill, Louisville, Ky.

15. Environment, by Dr. George Jenkins, Louisville, Ky. Discussion opened by Dr. J. W. Stone, Henderson, Ky.

16. Further Contribution in Non-Penetrating—Abdominal Wounds, by Dr. J. L. Wiggins, East St. Louis, Ill. Discussion opened by Dr. H. O. Pantzer, Indianapolis, Ind.

EVENING SESSION, AT 8 P. M.

Evans' Hall, corner Fifth and Locust Streets.

President's Address—Dr. Brooks F. Beebe, Cincinnati, Ohio.

Annual Address—The Age in Which We Live, Dr. Curran Pope, Louisville, Ky.

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SECOND DAY—MORNING SESSION, 9 A. M.

I Election of Members.

II. Report of Committees.

III. Unfinished Business.

IV. New Business.

V. Miscellaneous Business.

VI. Election of Officers.

17. Surgery of Prostatic Enlargement, by Dr. August Schachner, Louisville, Ky.

18. A Brief on Prostatectomy, by Dr. G. Frank Lydston, Chicago, Ill. Discussion opened by Dr. J. R. Eastman, Indianapolis, Ind.

19. Catheters, Their Selection, Use and Abuse, by Dr. Wm. N. Wishard, Indianapolis, Ind. Discussion opened by Dr. Edward Linthicum, Evansville, Ind.

20. Hyoscine—Morphine Anesthesia, by Dr. Emory Lanphear, St. Louis, Mo. Discussion opened by Dr. Carl Viehe, Evansville, Ind.

21. The Radical Treatment for Inguinal Hernia, by Dr. P. H. Steward, Paducah, Ky. Discussion opened by Dr. W. F. Stirman, Owensboro, Ky.

22. Surgical Treatment of Goitre, by Dr. John R. Wathen, Louisville, Ky. Discussion opened by Dr. Edwin Walker, Evansville, Ind.

23. The Limitations of Surgical Interference in Neuropathic Patients, by Dr. F. P. Norbury, Jacksonville, Ill. Discussion opened by Dr. A. M. Hayden, Evansville, Ind.

24. Palliative Operations for Intra-Capsular Cerebral Hemorrhage, by Dr. A. E. Sterne, Indianapolis, Ind. Discussion opened by Dr. Sanger Brown, Chicago, Ill.

Adjourn for lnuch.

SECOND DAY—AFTERNOON SESSION, 1:30 P. M.

25. Pott's Disease in the Spinal Region, by Dr. Albert H. Freiberg, Cincinnati, Ohio. Discussion opened by Dr. J. T. Reddick, Paducah, Ky.

26. Physio-Therapy in Its Relation to the General Practice of

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Medicine, by Dr. Otto Juettner, Cincinnati, Ohio. Discussion opened by Dr. F. H. Maxam, Princeton, Ind.

27. The Relation of the Physician to Sanitation and Hygiene, by Dr. H. P. Sights, Paducah, Ky. Discussion opened by Dr. J. N. Hurdy, Indianapolis, Ind.

28. Auto Intoxication, by Dr. W. C. Abbott, Chicago, Ill. Discussion opened by Dr. L. Worsham, Evansville, Ind.

29. Sympathetic Ophthalmia, by Dr. L. D. Brose, Evansville, Ind. Discussion opened by Dr. Adolph Pfingst, Louisville, Ky.

30. Treatment of Acute General Peritonitis, by Dr. W. S. Wiatt, East St. Louis, Ill. Discussion opened by Dr. G. W. Varner, Evansville, Ind.

31. The Applied Anatomy of the Accessory Sinuses of the Head, by Dr. M. Radvin, Evansville, Ind. Discussion opened by Dr. D. M. Griffith, Owensboro, Ky.

32. Fistula in Ano, by Dr. Cyrus Graham, Henderson, Ky. Discussion opened by Dr. Chas. B. Harpole, Evansville, Ind.

When essayist is not present, paper will be read by title.

Middle Tennessee Medical Association.

We call the attention of our readers to the following card, which is sent to the profession in this section of the State, and trust that every doctor will make an effort to attend the meeting:

"Dear Doctor: Our next semi-annual meeting of the Middle Tennessee Medical Association will be held on November 21 and 22, at Nashville.

"We are particularly desirous of having this meeting more attractive, interesting and beneficial than any that has preceded it; however, this is dependent entirely on the individual efforts of the members. Therefore you are respectfully requested to give us a paper on any subject that you may choose.

"Kindly attend to this at your earliest convenience, as we wish to issue our programme two weeks before the meeting.

"Yours very truly,

Wm. Litterer, *Sec. and Treas.*

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Reviews and Book Notices

Transactions of the American Othological Society—Fortieth Annual Meeting. Hotel Arlington, Washington, D. C., May 7 and 8, 1907. Volume X, Part III. Published by The Society: Mercury Publishing Company, Printers, New Bedford, Mass. 1907.

We acknowledge with pleasure the receipt of this always welcome volume of transactions of one of the oldest societies in the United States. As usual it contains a collection of excellent papers on various topics connected with the subject, full of instruction and interest both for specialist and general practitioner, and all collectively show enthusiasm and industrious research and careful observation.

A Text-Book of The Practice of Medicine, For Students and Practitioners, by James Magoffin French, A.M., M.D., formerly Lecturer on the Theory and Practice of Medicine, Medical College of Ohio. Third Revised Edition; Illustrated by One Hundred and Ten Engravings in the Text, and Twenty-five Full Page Plates in Tints and colors. New York. William Wood & Company. 1907.

This work is one of the very best of the kind presented to the profession recently, and deserves to become popular, for it is above all things most valuable as a guide to all needing assistance in the diagnosis and treatment of diseases of women. The work is thorough, comprehensive and systematic. The illustrations are well selected, many of them original and so numerous as to render any gynecological step clear. The text is concise, but clear and practical. We are highly pleased with the book and cheerfully recommend it.

The Diagnosis and Treatment of Diseases of Women, by Harry Sturgeon Crossen, M.D., Clinical Professor of Gynecology, Washington University; Gynecologist to Washington University Hospital and Chief of the Gynecological Clinic; Associate Gynecologist, St. Louis Mullanphy Hospital; Consulting Gynecologist to Bethesda Hospital, St. Louis Female Hospital and St. Louis City Hospital; formerly Superintendent of the St. Louis Female Hospital; Fellow of the American Association of Obstetricians and Gynecologists; Ex-President of St. Louis Obstet-

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rical and Gynecological Society; Member American Medical Association, Missouri State Medical Association, St. Louis Medical Society, etc. With Seven Hundred Illustrations. C. V. Mosby, Medical Book and Publishing Co., St. Louis. 1907.

The popularity of this well known book is amply illustrated by its appearance in its third edition so soon after the preceding edition. A large part of the text has been re-written and careful revision is apparent on every page. The work has been sensibly enlarged, and much new matter added. The most important changes have been made in the chapters on infectious diseases, the diseases due to animal parasites, and the diseases of the nervous system. Especial attention has been given to tropical diseases now being studied so carefully, and in which new and important developments are being made every day. It is an excellent text-book for students, especially being commendable for compactness, and at the same time thoroughness.

Transactions of the Seventy-fourth Annual Session of the Tennessee State Medical Association, Nashville, 1907. The Seventy-fifth Annual Session will be held in Knoxville, commencing second Tuesday in April, 1908.

This volume of transactions of the 74th meeting of the Tennessee State Medical Association reflects much credit for its preparation upon the genial secretary of the body, Dr. George H. Price, and the character of the papers presented and their accompanying discussions deserve much commendation upon the eminent and progressive physicians comprising the dignified body. The papers invariably are of a high order of excellence for scientific value and practical importance.

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Publisher's Department

Treatment of Uterovaginal Catarrh.

BY C. E. BRANDENBURG, M. D., N. Y. CITY.

Fifeen months ago Mrs. X. came to me for treatment, giving the following history: Six years previous she had a miscarriage, since which she had been troubled with a profuse leucorrhea of a very foul odor. At her menstrual period she suffered greatly and flowed excessively. On examination the cervix was found to be nearly four times its normal size and so badly eroded as to haev every appearance of a cancer, and had been mistaken for such by one physician. The uterus was soft and baggy and very much enlarged. She had been to the hospital on two occasions, and each time had been curetted, but this seemed only to aggravate the general condition. For over a year I treated her with every means at hand, but to no purpose. I was making preparations for an operation, which would have meant the removal of the uterus, when my attention was drawn to glyco-thymoline, and I determined to give it a thorough trial before operative measures were to be further introduced. In intrauterine douche of glyco-thymoline in 25 per cent hot solution was administered, and lamb's wool tampons saturated with glyco-thymoline pure was used. She began to improve from the first application. The leucorrhea became less and the odor disappeared entirely. The cervix took on a healthy look. The uterus decreased in size and became firm; in fact, she is now nearly well after nine weeks' treatment with glycothymoline.

The Value of Codeine.

The *Cleveland Medical Journal*, quoting from the *Denver Medical Times*, concerning codeine, states that, according to Butler, "it is less depressing and more stimulating than morphine, does not constipate, cause headache or nausea, and rarely leads to the formation of a habit. Codeine seems to exert a special, selective,

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sedtive power over the pneumogastric nerve, hence its value in irritive, laryngeal, pharyngeal and phthisical coughs with scanty secretion. Like morphine, it has proved of value in checking the progress of saccharine diabetes, and it has been usel for long periods without the formation of the drug habit, inasmuch as when glycosuria was brought to a termination by dietary and other measures, the cessation of the use of codeine was not followed by any special distress. The effects of codeine on the alimentary canal are remarkable, in that it assuages pain as well or better than morphine, and nevertheless does not check the secretions of peristalsis notably, unless the latter is excessive, as in dysentery." In view of these facts, it would seem that Antikamnia and Codeine Tablets are a remedy which should find a wide field. Prof. Shcwarze (Therapeutische Monatschefte), in writing upon the treatment of different forms of dysmenorrhoea, and the different forms of congenital deformity of the uterus, states that the coal-tar analgesics are of much use, as well as the preparations of iron and sodium salicylate. In many cases it is necessary to administer codeine in small doses, and the tablets of "Antikamnia and Codeine" would seem to have been especially prepared in their proportions, for just these indications.

Remember that the dripping of the urine in adult life usually denotes the overflow of a distended bladder, possibly occasioned by muscular relaxation of bladder, or the commencement of hypertrophy of the prostate. Sanmetto is the indicated remedy.

Some of the indications for Sanmetto are: Vesical irritation and atony; enuresis, due to atony; incontinence of urine in children, due to a weak bladder; dribbling of the urine in the aged, not due to paralysis or growths; urine expelled upon exertion, as coughing; cystitis; catarrhal discharges from bladder or genitalia of male or female; seminal emissions; prostatitis, enlarged prostate and pre-senility.

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor
SAMUEL S. BRIGGS, M. D., Associate Editor

VOL. CI. NOVEMBER, 1907. No. 11

Original Communications

MASTOIDITIS, ITS MANAGEMENT AND TREATMENT.

BY I. E. WELLS, M.D., YOUNGSVILLE, TENN.

Mr. President and Gentlemen:

Before taking up the subject direct, it will be desirable to notice a few of the anatomical points of the mastoid portion of the temporal bone. The mastoid portion is situated at the posterior part of the bone, and, is continued below into a conical projection, the mastoid process, the size and form of which varies somewhat. On the inner side of the mastoid process is a deep groove, the digastric fossa, for the attachment of the digastric muscle, and running parallel with it, but more internally, the occipital groove, which lodges the occipital artery. The internal surface of the mastoid portion also presents a deep curved groove, which lodges a part of the lateral sinus; into it may be seen opening the mastoid foramen, which transmits a vein to the lateral sinus.

A section of the mastoid process, shows it to be hollowed out into a number of cellular spaces, communicating with each other,

(Read before a joint session of the Medical Societies of Robertson County, Tenn.; and Logan and Todd Counties, Ky., October 1, 1907.)

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called, the mastoid cells. They may open by a single or double orifice into the back of the tympanum, and are lined by mucous membrane, continous with that of the tympanum, and probably, form some secondary part to the organ of hearing. The mastoid cells, like other sinuses of the cranium, are not developed until after puberty, hence it is more prominent in the adult. The ossification of the petrous and mastoid portion is developed by six centers, and during the first years of life the points of union between these different portions are very vascular, so that inflammatory products can easily break through these vascular walls and give rise to a collection of pus in the soft tissues behind the auricle, a condition, which is of frequent occurrence in scrofulous children.

For convenience I shall divide this disease into external and internal mastoiditis.

In external mastoiditis we have a primary inflammation of the mastoid cells, without any involvement of the tympanic cavity. This division is rare, but such cases do occur and have been reported. The congestion first appearing in the periosteum covering the mastoid itself.

Etiology.—The cause of external mastoiditis is frequently obscure. It may be due to cold, injury, or an extension of a furuncular condition of the external meatus. The external form of this disease, may run its course in a few days and rapidly subside or suppuration may take place.

Symptoms.—The auricle generally stands out prominently while the tissues over the mastoid are œdematous, red and very sensitive to touch. Pain in the mastoid is often severe; fever generally moderate; hearing is usually unaffected.

The second form, or internal mastoiditis, I will divide into two divisions—first, primary acute inflammation of the mastoid cells, and second, acute inflammation of the mastoid occurring in connection with acute suppurative otitis media.

Etiology.—The cause of the first form of this division may be due to cold, trauma, lagrippe, syphilis, or may develop spontaneously.

Symptoms.—The symptoms are pain over and in the region of

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the mastoid, which usually becomes very severe, and throbbing tenderness on pressure over the mastoid bone, and the pain seems to be deeper than in the external form. But in some cases it will be impossible to tell whether the mastoid cells are implicated or not, until a free incision is made down to the bone, and the latter examined for a sinus, and it would be well in such cases to open the cells to see if pus has formed. The last part of the second division or acute inflammation of the mastoid cells occurring in connection with acute suppurative otitis media, is the form of inflammation of the mastoid cells that is most frequently observed. This division of this disease starts generally in the naso-pharynx, and spreads by the eustachian tube to the tympanum, and thence through the antrum to the mastoid cells.

Etiology.—The exciting cause of this division of mastoiditis, may be, exposure to cold, the exanthematous diseases, diphtheria. tonsilitis, bronchitis, typhoid fever, tuberculosis, syphilis, la-grippe, sniffing up salt water for the relief of nasal catarrh.

In nearly all cases of acute middle ear trouble there is some involvement of the mucous lining of the mastoid cells.

Symptoms.—The most prominent symptom of this form or division of internal mastoiditis is pain in the mastoid process, which often radiates out into the temporal region and downward and forward into the teeth. Great pain is felt when percussing the bone, or when firm pressure is made over the mastoid. Other symptoms are increase of surface temperature, bulging of the posterior and upper portion of the drum head and associated with a general elevation of temperature. The condition of both mastoids should be examined and compared as in some subjects, pressure over the mastoid produces pain. Any of these forms of acute inflammation of the mastoid cells may terminate in recovery without suppuration. But in the second division, or internal mastoiditis it most frequently does occur.

Prognosis.—The prognosis is generally favorable in simple, uncomplicated cases.

Management and Treatment.—If the physician is fortunate enough to see a case of acute inflammation of the mastoid cells, in its first stage, before pus has formed, he should have the patient

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put to bed and kept quiet. Give a light diet consisting principally of milk. Calomel should be administered in one-tenth grain doses every hour until a laxative effect has been produced. Tincture of aconite in one drop doses is an excellent remedy in the early stages. Leeches should be applied to two or three places over the mastoid. The ice-bag or cold coil should be applied over this region. But cold, under no circumstances, should be applied after the first stage. I mention the blister to condemn it, for I think it tends to aggravate the disease. If under the use of anti-phlogistic measures and the application of cold, the pain and tenderness rapidly subsides, and the temperature shows no evidence of septic absorption, the chances are that, no operation will be necessary. But, on the other hand, if pain continues, temperature high, and severe pain on pressure over the mastoid, the indications are for an immediate operation.

In the first division, or external mastoiditis, the preparation of the patient is the same as in the second, or mastoiditis internal. The side of the head should be shaved within two and a half inches of the auricle. A thorough cleansing of the parts by soap and water and afterwards by bichloride solution 1 to 3000. The auricle should be pulled down by an assistant, then an incision should be made through the soft parts down to the bone, from the extreme tip of the mastoid to a point just above the upper border of the auricle, pushing aside the soft parts and, if the bone has become carious, this should be removed with chisel and gouge. If the mastoid cells are not affected this will be all that is necessary.

In mastoiditis internal, should chisel an opening into the cells, establishing communication with the antrum and attic, examining all portions of the mastoid, removing all softened bone and granulations, etc. In the last part of the second division, or acute inflammation of the mastoid, occurring in connection with acute suppurative otitis media, after using the anti-phlogistic measures, if the pain is not relieved and the drum head is bulging, a free incision should be made. If inflammatory symptoms do not subside, the ear should be douched with a saturated solution of boric acid every two hours, or according to the amount of pain

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and discharge present. In case of scarlet fever or diphtheria, the ear should be syringed out at least twice a day with bichloride of mercury solution 1 to 3000.

After the mastoid cavity has been opened up and cleaned out, should irrigate the cavity with bichloride of mercury solution 1 to 3000, and should try and force some of the solution through the antrum and the external meatus.

The cavity in the bone should be packed with strips of moistened iodoform gauze. May then take a few sutures in the upper and lower angle of the wound to lessen the size of the opening; should then cover the wound and auricle with iodoform gauze, over this place bichloride gauze and over all this absorbent cotton and bandage. Unless the patient has fever and pain coming up, the packing in the mastoid should be left at least two or three days. After the first dressing, should substitute boric acid gauze for the iodoform—the dressing should be applied lightly so as to allow the cavity to fill up as rapidly as possible.

After operation it is desirable to keep patient in bed and quiet for a few days, or until the temperature becomes normal. While there is fever let the diet be light, consisting of beef tea or milk. Particular attention should be paid to the general health of the patient. Cachectic or scrofulous patients should have special care. Give good tonics—codliver oil, iron, strychnia or hypophosphites; while syphilitic or tubercular patients should have appropriate constitutional treatment.

Acute Nephritis, with Citation of a Case.

BY D. G. SIMMONS, M. D., ADAIRVILLE, KY.

Attacks of acute nephritis, of greater or less violence, are of such frequent occurrence, I have thought the citation of a case which came under my observation, with some reflections on the subject, might prove interesting on this occasion. In preparing

(Read at a joint session of the Medical Societies of Robertson County, Tenn., and Logan and Todd Counties, Ky., Guthrie, Ky., October 1, 1907.)

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this paper for our consideration today it will be my purpose only to call attention to the frequency of this form of inflammation, to some of the causes of its development, and to the treatment which I, as a country doctor, have frequently found most efficacious, without reference to its minute anatomy and pathology.

I assume that the possibilities of bacteriology and the finer deductions from chemistry as manifested in the physiological and pathological processes of the various fluids and tissues of the body in their relation to each other are not for the country doctor, whose time and attention are engrossed in his efforts to assist nature in repairing injuries and building up waste places as he finds them in his practice, keeping, at the same time, his weather eye on all medical progress and new discoveries which have been sufficiently tested and their usefulness established, and adding them to his armamentarium as occasion may require. But, notwithstanding the country doctor finds but little time for bacteriological and laboratory work, he has his uses to posterity in crystallizing and establishing the best and most successful treatment of diseases, in that he has such large opportunities to observe diseases and to observe the effect of medicine in the different manifestations of diseases, and thus he gleans, in time, a harvest of practical wisdom, which, when aggregated, cuts no mean figure in the summary of the world's medical knowledge. All honor to the hard-worked and frequently illy-appreciated and illy-requited country doctor, who, latterly—I will here take occasion to say, though—is bringing discredit on himself and compromising his own merits and usefulness by too frequently transferring his patients to the city specialist, when he might, in most instances, treat them himself at home quite as successfully.

When we stop to consider the great abundance of "toothsome" articles of diet which this highly-favored country and age produce, and the constant temptation to indulge in highly seasoned comforts to excess, and when we consider the further fact, after these frequent indulgences to excess, it devolves mainly on the kidneys to eliminate from the system the poisons resulting from these abuses, the only wonder is these long suffering organs do not break down and refuse to honor the large drafts made upon

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them more frequently than they do. In point of fact, they do send out distress signals quite frequently, but we almost as frequently refuse to recognize them till serious organic diseases and impairment or failure in function cram the knowledge down our throats, *"nolens volens,"* and then it becomes a serious matter to repair the injuries.

I am led to believe that the profession too often overlooks disturbance of the kidneys, attributing complaints made by patients, which should direct attention to the kidneys, to disturbances of other organs and functions, but, in the majority of such cases, fortunately, the versatile *"vis medicatrix naturae"* is sufficient to bring about resolution by a few days of restriction of diet. If the dread name of Bright's disease, which is uppermost in the mind when albuminuria is discovered in the urine, could be forgotten, and cases of inflammation of the kidneys could be recognized promptly and treated, it might be better for both patient and doctor, for, as a matter of fact, the acute stage of inflammation of the kidneys, if early recognized and properly treated, is usually quite manageable.

The case to which I wish to call your attention was in a girl about fourteen years of age, of good family and personal history, and in good health prior to a few days of the time I first saw her.

On September 4th, 1906, her father reported her case to me, describing it as a general swelling of only a few days' duration; for this I prescribed small doses of calomel and ipecac, and dram doses of sulphate of magnesia every four hours, and directed him to save up twenty-four hours' passage of urine, measuring the quantity, and to bring me a portion for examination. When he did this I found that eight ounces of dark, turbid urine was all that had been passed in twenty-four hours, and this contained a very large proportion of albumin. Upon visiting her the next day, I found a general anasarcous condition of the whole body, the eyes almost closed, and the extremities so large and heavy she could scarcely raise them. She had a temperature of 100 degrees, pain in head and back, a good appetite and fairly good sleep; the same medical treatment was continued, and a flannel

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bandage of ten inches in width was carried around the waist tight enough to fit snugly, and the upper border was tacked in several places to the inside of the garment to prevent its gathering into a roll around the waist; the purpose of this bandage was to maintain a uniform temperature over the kidneys, and to prevent any sudden chilling of the surface; a little ground mustard was sprinkled over the inner surface of the bandage to counteract the pain in the back. Inquiry elicited the fact that she was very fond of meat, eating heartily of it each meal. In regard to diet, she was directed to confine herself to milk, bread, fruit and vegetables, and to abstain totally from meats, eggs, proteids, on the hypothesis that such articles of diet would tax the kidneys in their lame condition beyond their capaciy for elimination, and thus aggravate the condition we were trying to correct. There is, perhaps, no more important rule of treatment in this disease than this manner of prohibiting albuminoid articles of diet.

There was no history of any previous specific fever, or any special outdoor exposure to cold or wet. The presumptive cause of the kidney inflammation was exposure of the back during the wet and cold nights as they were growing longer and colder; there had been a protracted cold and rainy spell of weather. Just at this point I wish to call attention to what I regard as a vicious habit pretty generally practiced, especially during the early fall months, when the nights are beginning to grow longer and colder, but still not sufficiently cold to exercise much care in keeping well covered. The habit I allude to is that of removing all the clothing worn during the day, and wearing only a thin gown or night shirt at night; this garment, in turning and tossing during sleep, as children are wont to do, and as many grown persons do, soon climbs up under the armpits, and this virtually secures no protection to the surface of the body and extremities beneath the shoulders. This exposes the surface all over the viscera, drives the blood to the central organs, and thus invites congestion and inflammations. The kidneys are so deeply imbedded in the tissues, it would seem, that they would be removed from this cause, but, in point of fact, there are no other organs so easily affected by exposure of the back. The two-piece pajamas, or the union

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suits, if one should prefer them, secure much better protection to the whole surface for night wear.

September 7th, two days later, the temperature was nearly normal, swelling very much reduced, the kidneys passing nearly normal quantities of urine, bowels acting freely, but the albumin in the urine were still abundant; same medical treatment of calomel 1-5 gr., ipecac, 1-10 gr., and one dram of salts, was continued, and the same regimen kept up, although the patient howled for meat at every meal.

September 9th, four days later, temperature normal, swelling almost gone, but the albumin not perceptibly reduced. The former treatment was replaced by the following prescription:

Tinct. Digitalis .....dr. 2
Liq. Acetate Ammonia, Spirits Nitrous Ether (aa)...oz. 2

M. Sig.—One teaspoonful in water every three hours; continuing abstemious diet.

September 12th: Anasarca slightly increased, without other notable change; a half dram of sulphate of magnesia was added to each dose of the preceding prescription.

September 14th: Symptoms unchanged, and she was put on the following prescription:

Sulphate of iron .....gr. 1
Sulphate of magnesia .....dr. ss.
Bicarbonate potassa .....gr. x
Aqua pura .....oz. viii.

M. Sig.—One dose, to be repeated every three hours.

September 23d: Patient much better in all respects; albumin much reduced; same treatment continued.

October 7th: Swelling all gone, together with all outward symptoms, except a slight trace of albumin; same treatment continued.

November 1st: Patient put upon mist. ferri et ammon. acetas, one dram three times a day, and patient dismissed, practically well, and her health has remained good up to this date, about twelve months later.

There are several diseases which are peculiarly prone to the development of nephritis, as a sequence during convalescence.

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The worst offender in the list are those involving an eruption or some form of general inflammation of the skin. The functions of the kidneys may, where the kidneys are not functioning properly, be in some sort performed by the skin vicariously, and *per contra*, if the skin, from disease or other cause, is inadequate to the performance of its functions, the kidneys come to its rescue vicariously through this treaty of mutual help in time fo need. During this double duty imposed on the kidneys through this incapacity of the skin during convalescence from scarlet fever, for instance, if the patient is exposed to wet or cold, or any sudden chilling of the surface, the blood is driven from the skin, which is rendered unusually sensitive by previous disease, to the internal viscera, producing congestions which will be especially disastrous to the weakened and already overworked kidneys; hence the frequency of nephritic troubles following scarlet fever, measles, smallpox, etc.

I can recall five cases of Bright's disease in children to which I was called, and I found upon examination that the children had scarlet fever recently in so mild a form that the parents, not suspecting its existence, had treated the cases with simple domestic remedies without calling in a doctor until the general swelling excited alarm, and, previous to my seeing them, when they seemed to the parents to be well, they were allowed to eat anything and expose themselves to any weather, as when in health. I always find in these cases very red and glassy tongues and throats, such as are seen in most well pronounced and violent cases of scarlatina. In all of these cases, the rules of treatment previously outlined were adopted substantially, and good recoveries were made.

Therapeutic Tips.

BY E. S. M' KEE, M.D., CINCINNATI, OHIO.

Eye Lotion.—Among the many Bulle things in the *Medical Bulletin* is the following soothing and cooling eye lotion:
Acidi boracici, sodii chlorid (aa) 1.35; aquæ menth. piperitæ,

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aquæ camphoræ, aquae distillatae (aa) ad. 120.00.—M. S.—Bathe the eyes freely.

Yawning More Profitable than Polite.—In Austria, yawning is recommended and practiced as a method of vocal and health culture. Deep yawning with arms outstretched insures complete change of air in the lungs. Six or eight yawns, each followed by swallowing, is a most beneficial means of treatment. This exercise, with deep breathing, is the best means of strengthening the respiratory muscles and organs, while it gives astonishing relief in catarrh of the throat. This practice persisted in by singers causes the tonsils and uvula to retract and harden, and the clear passage gives the voice greater volume and improved quality.

For Dressing Wounds.—The following powder is employed in place of iodoform by Genevrier, as described: Boracic acid, bismuth subnitrate, powdered camphor, equal parts. He also finds very valuable sodium borate previously pulverized as fine as possible, and preserved in a flask closed with a piece of sterile gauze, through which an impalpable powder can be shaken. This acts like oxygenated water equally as a disinfectant, a deodorizer and a perfect detergent, which sweeps away all impurities by its production of gas. It is inodorous, not painful, toxic or irritating, and can consequently be placed in any hands for use; further, by its alkaline action it favors the cicatrization of wounds, and can be employed upon mucous membranes and the most sensitive epidermal tissue. It arrests capillary hemorrhage and blanches and decolorizes. Its action is proportional to the requirements, and it is exercised only when the wound suppurates or secretes. Although used in excess it never forms crusts on the wounds, sodium perborate may be used to prepare extemporaneously an oxygenated water of any strength, of alkaline reaction, and consequently not at all irritant, at any rate, up to a volume of 1-4, which fact renders it practically useful to keep on hand.

Tincture of Iodine.—Mittlebach, in the *Bulletin of Pharmacy,* complains bitterly of the use of iodine in the present U. S. P. formula. Bottles had been returned to him by physicians which contained crystals, and they complained in many instances that

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he had given them the old-fashioned Churchill's tincture. Prof. Remington, Chairman of the Revision Committee of the U. S. P., has explained that the small amount of potassium iodide was added to the formula in the new Pharmacopeia to prevent deterioration in the strength of the product which had caused so much trouble in the past, and which had, in many instances, brought pharmacists into embarrassing relations with the law.

The Iodine Test for Semen.—In case of old stains of linen with semen it has been found difficult to identify the spermatozoa with the microscope. Florence, of Lyons, reports (*Arch. Anthropologic Criminelle*) a chemical test which promises to be of much value. The reagent is one used in testing alkaloids known as the tri-iodide of potassum (KI 3). Formula: Iodide of potassium, 1.65; iodine, 2.46; distilled water, 30.00. Place a drop of this liquid beside a drop of a solution obtained by moistening a seminal stain on the slide, and large numbers of pecularly brownish-red, pointed crystals appear. They closely resemble hemine crystals, and are rhomboidal in shape.

Dr. W. F. Whitney (*Baston Medical and Surgical Journal,* 1907) also obtained the reaction, but considers its value chiefly negative, as alkaloids give a precipitate with the reagent. He was successful with the following method of examining a seminal stain even two and a half years old. A drop of the fluid obtained from moistening the stain is evaporated and fixed by a flame. The film is stained with eosine and methyl green and mounted. At the base of the head of the spermatozoa is a hemispherical portion, which stains a deep green, while the anterior part and tail stain red. This identifies them at once, as there is no other oval cell or sphere which has an eccentric cell or nucleus. He, furthermore, claims that the test proves them to be human, as in no other animal is there a deep staining. This test, combined with Florence's mentioned above, ought to reach a conclusion without difficulty.

Dr. Wyatt Johnosn, in Whitney's article, states that he has obtained the reaction in stains a year old. He also confirms Florence's statement that other secretions of the body, as blood, urine, sweat, saliva, tears, bile, milk, mucus, will not give the reaction.

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The semen of animals sometimes gave a doubtful reaction. The subject is fully discussed in Shoemaker's "Materia Medica and Therapeutics," sixth edition.

Bronchial Cough, Tight and Irritating.

Codeine sulphatis	0.25
Ammoniæ chloridi	3.00
Elixir terpini hydritatis N. E.	30.00
Syrupi pruni virginiae	30.00

M. S.—One teaspoonful every three hours.—*Wade Thrasher.*

Offensive Perspiration.—Guaiacol cinnamic acid (stryacol) in one-half gramme doses three times a day, is recommended by Dr. Arthur W. Thomas. This antiseptic seems to be eliminated largely by the skin. Dr. P. Sheey suggests pilocarpine, picrotoxine, nitrate of amyl, and especially the latter. He has found picrotoxine beneficial in the sweating of phthisis and nitrate of amyl in that profuse perspiration a sequella of influenza.

The Dose of Sodium Salicylate.—Prof. G. Rauzier, Montpelier, in his "Lecons de Therapeutique Pratique," recommends the dose of sodium salicylate as much smaller than is generally given. Many would order a dose of ten grains, to be repeated every hour till the pain is relieved, and continued every two hours for the remainder of the day, so that the patient gets probably 160 grains during the first twenty-four hours. Rauzier thinks this is excessive. He thinks forty-five to sixty grains are sufficient, and he orders a half-gramme dose (gr. 7 1-2) every three hours. Acute rhuematism, like other diseases, may have its local peculiarities, and possibly in France the common type yields to smaller doses, but there is no reason to believe that larger doses are attended with danger.

Proved Alcohol an Antidote to Phenol.—Dr. Seneca D. Powell, who died recently at Greenwich, Conn., drank carbolic acid three years ago to prove that alcohol was its antidote. He survived the immediate effects of the poison, but his health was shattered, and he never recovered entirely. His demonstration that alcohol is an antidote to phenol has been the means of saving many lives.

Salocresol in Chronic Lymphadenitis.—Dr. Streffer relates in *Therapeutic Neuheiten*, 1907, what flattering success he had with

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this remedy in this class of cases. First cleaning and drying the skin thoroughly, the salocresol is painted on the inflamed gland in full strength. The neck is then bandaged with cotton and cloth. The amount used was generally about twenty grammes, and the application was made in the evening after the washing of the child preparatory to putting it to bed.

Big Bichloride Tablets.—E. V. Esmarch, of the chemical fabrick of Merck, in Darmstadt, has brought out tablets of sublimate of larger size than usual. The tablets are of five to ten grammes, with equal parts of coarse salt, making pastilles of nearly the size of a silver fifty-cent piece and one dollar. The price is 10 per cent cheaper than those of the usual size. In these larger pastilles the amount of coloring matter is reduced so as not to be too great.—*Zeitschrift fuer Med. Beampten.*

Deaths from Calomel.—Fatal cases of poisoning from calomel have become much more infrequent of late years than formerly. Observant medical men attribute this decrease to the greater purity of the calomel of the present time, as compared to that of some years ago. Calomel was formerly frequently contaminated with bichloride. The recognition of this fact during the American Civil War and the subsequent washing of all the product used by the careful practitioner, no doubt saved many lives, besides numerous cases of salivation which followed the heroic and frequent administration of calomel in the South. Some cases were probably due to idiosyncrasy, but by for the most of them were due to contamination with bichloride, or to changes taking place subsequent to ingestion, which changes many think are the transformation of calomel into bichloride.

Sinnhuber, in the *Therapeutische Monatshefte,* gives the details of a case where a man twenty-four years of age succumbed to the administration of eight three-grain doses of calomel. Although danger signals were thrown out, the calomel was continued for a time, and the man died on the twenty-fourh day.

Idiosyncratic intolerance of calomel is, unfortunately, not rare. The tolerance of calomel, as well as other mercurial salts, is very varied in different individuals. One case is on record where a man took, in the course of twenty-three days, 285.2 grains of

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calomel without the slightest disturbance of his system. On the other hand is reported the case of a boy, aged fourteen years, who took five grains of calomel, became comatose and in that condition died. In thirty years we find eight fatal cases reported in the literature. Besides these cases are a great number of intoxications which ended in recovery. Calomel should always be administered with circumspection, and discontinued on the appearance of the first danger signal.

Salt Not Incompatable With Calomel.—We must look for other causes than the amount of salt usually contained in cooking to cause the salivation from calomel. Carracido has published in his very careful investigations into the truth of the fact that salt as contained in soups and in cooking is incompatible with calomel, and, as many think, converts the calomel, or a portion of it, into the bichloride. His investigations are quite voluminous, and seem to be exact. While he admits that salt does, in an amount far in excess of that used in cooking, exercise on calomel a decomposing effect, but the amount of bichloride formed is far below a toxic doe. Among the causes of intoxication he suggests the formation of colloidal mercury, produced by the action of the alkaline juices of the system, the albuminoids, hemoglobin, etc., but more particularly cell protoplasm.

The Therapeutics of Chewing Gum.—The great American habit of bolting meals seems to be counteracted in a measure by chewing gum. A meal insufficiently masticated lacks of the salivary amylolitic aid to gastric digestion. Chewing gum results in a supplementary insalivation within the stomach, from swallowing the saliva poured out by reason of chewing gum. Though repulsive in the extreme, especially on the street, it not only aids digestion, but also aids it indirectly by cleansing the teeth, thus keeping them in good order and preserving digestion. Thus it seems that we cannot scientifically oppose this disgusting habit.

Surgical Treatment of Goitre.—Dr. Solomon Colis-Cohen has reported three cases in which he used the serum treatment. In early cases this is not necessary. Ordinarily the old treatment was sufficient, viz., rest, hygienic treatment, drugs, such as ergot,

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picrotoxine, strophanthus and thymus and adrenal gland. He tried adrenalin first, and generally it proved efficient; if not, he gave thymol, and, if necessary, both together. These failing, he went back to ergot and picrotoxine. He had recently heard a paper on the surgical treatment in which a mortality of 40 to 50 per cent was considered a good result. Ten per cent was considered phenomenal. He would be ashamed of a mortality of 10 per cent. from medical treatment.

A Temporary Coating for Wounds.—Mastic, 20 grammes; chloroform, 50 grammes; linseed oil, 20 drops, makes a good temporary dressing for wounds. This is brushed over the cleansed injury and covered with cotton, which is bandaged in place. This solution dries as a sort of a varnish, and prevents the entrance of infection. It may be dissolved and removed by ether or chloroform.

Lotion for Mosquito Bites.—Royet (*Lyon Medical,* June 2, 1907) recommends a solution of calcium hypochlorite, 1 per cent, as an excellent topical application for the relief of bites of mosquitoes and of insects in general.

Boric Acid as an Eye Wash.—A saturated solution of boracic acid at the normal temperature is just about equal in density as that of the tears or a salt solution of 14-1,000, or one and one-half times that of the blood plasm. Being thus isotonic with the tears, it forms an ideal medium with which to cleanse the delicate epithelium of the cornea and conjunctiva.

To Remove Freckles.—Take of pure iodine 24.00, potassium iodide 12.00, glycerine, 12.00, rose water 120.00; paint this on the freckles and after twenty minutes remove the iodine. Stain with a mixture of three ounces of hyposulphite of soda to a quart of water. In mixing the first solution, dissolve the iodide in a small part of the rose water, to which has been added a drachm of glycerine. Rub together and add the iodine gradually, rubbing until in solution. Then add the rest of the prescription.

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Selected Articles

The Prostate from the Surgical Standpoint.

BY CHARLES S. BENSON, M.D., HAVERHILL, MASS.

The literature on the prostate gland is most voluminous. One can find carefully prepared statistical reports; papers proving to the writers' satisfaction the only and best method of operative attack. Others show conclusively that catheter life is the only way to handle these sufferers, until the outraged bladder settles the question in its own way.

For all exhaustive treatises, anatomy, functional physiology, histology and pathology, I refer you to the interesting works of Denver, Young, Willy Meyer, Guiteras, Murphy, Chetwood, Keyes, Watson and a host of others. It is a simple matter to abstract any and all of these writers, but of what avail to you and me, for such would be inferior to the originals which lie within your reach.

My personal experience is confined to but few cases, all done by way of the perineal route, and all cured, which fact is of little value considering the small number, for the next few may go the other way.

As an interne, however, I assisted at no small number of prostatectomies, and cared for these afterwards. Most were done suprapubically, and I have since been rather prejudiced against this method, for convalescence was stormy and mortality was pyrotechnical, as I look back on the fistulæ, and infections of the prevesical space.

Since this paper was presented in the winter I have added two cases only, one of which is now two weeks in the hospital and apparently doing well. This is my only case operated upon by the suprapubic route, and for the reason that it seemed best to divide the operation into two stages.

With only these few prostatectomies to my credit, it may seem presumptious to address you, but I crave your indulgence for so

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doing and further ask your tolerance in that I may make these remarks personal, not abstractive, nor quotative, merely as the subject appears to myself. Suppose, then, we discuss the prostate gland along the following lines:

1. Is the patient with a prostate which is symptomatic, better for being subjected to operation, or should he be advised catheter life as long as possible, following by ultimate operation when catheter life is no longer possible or endurable?

2. If operation is the desideratum, what then constitute the indications for operation?

3. If not operative, is there any other treatment apart from or combined with catheterization?

4. If operation, what shall be the method of attack?

5. And perhaps this would have better come first, although I question it: What constitutes the symptomatology of hypertrophy of the prostate gland which establishes the diagnosis?

6. Prostatism without hypertrophy of the gland, its causes and treatment; the confusion of this with true hypertrophy of the prostate.

Concerning the first proposition, namely, catheter life or operation, there has been during the past several years a very great diversity of opinion as to the preferable means of procedure, and today it is still a very much mooted question, although I think surgeons are coming nearer together as to the advisability of the earlier operation.

For my own part, it seems to me after diagnosis is established, that the earlier we operate the better the chance of life, the better the chance of complete symptomatic recovery.

To pursue the old course of using the catheter as long as the patient could be made comfortable by such means, and ultimately operating when the patient's condition had become desperate from cystitis and ascending pyelo-nephritis, is wantonly running up the mortality rate and giving us simply palliative surgery. The fact that in individual work the mortality of all methods of operation is between four and six per cent would seem to me a great argument in favor of the earlier operation, before we have infective complications.

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The catheter is of the greatest use in establishing the diagnosis, and every patient should be kept under observation for a few months before deciding upon operative measures; but once the diagnosis is unqualifiedly established, the sooner we operate the better.

When I say diagnosis, I mean more than merely that a patient has hypertrophy of the prostate; I mean that this patient has more than merely nocturnal frequency of micturition. I mean, more especially, that urination is difficult to start, is what we call stuttering and stammering during the act; stops slowly with considerable dribbling and soiling of the clothing, and that the relief which ordinarily comes from emptying of the bladder is not experienced by the sufferer from prostatic hypertrophy.

In other words, to go only a step further, we now use the catheter and establish that the patient has four or more ounces of residual urine after urination.

Now it is perfectly possible for this patient to have this amount of residual urine and not have cystitis. I believe that with these symptoms it is not necessary to subject this patient to years of catheter life in the future, but by operating at this time we can save his inconvenience and also get a symptomatic and actual cure.

In this connection it is only fair to say that there are certain types of cases in which operation is probably the last resort after the case has been considered most deliberately, and yet for the most part I think operation should not be undertaken or considered at all.

I refer especially to those cases coming to the practitioner, who have been so long sufferers from an enlarged prostate with its damming back of the urine, whether or not depending at the present time for their visit completely on catheterization. These patients have an atonic bladder, and operation will not cure or relieve symptomatically this condition. It should be undertaken only when there is actual danger of death, in patients comparatively young and to whom every year of life is of the greatest importance, knowing that although you remove the hypertrophy, you will go on to the end with the catheter, and our operation has

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been done simply to provide the means of introducing the catheter.

Another class where it seems to me operation is questionable, is in old cases which, at the time of being seen, already possess infected bladder and kidney. By all means, in these cases, I should advise a long treatment by catheter and irrigation, unless the case is so desperate that suprapubic drainage affords quickest relief for the infected condition, if there is any relief at all to be obtained. These last cases can only be judged on their individual merits.

There is no dogmatic position of No operation or Operation. One thing is very certain, however. Any operation which takes more than a few minutes to perform will certainly put your patient on the wrong side of the mortality statistics.

To take up the next topic: The desirability of operation being established, what then are the indications?

It almost seems as though I had answered this question in the preceding paragraphs, but it will do no harm to repeat.

For me, at least, I believe that operation is indicated when, upon rectal examination, we find a pronounced enlargement of the prostate gland. When there is difficulty in starting the urinary stream, and, I might say, difficulty in stopping the same, with or without necessity of using the catheter. In addition to this, the discovery of a few ounces of residual urine. These I think, after proper observation, justify advising the patient to submit to operation and enable the surgeon to hold out the prespect of a cure and to inform the patient that taken at this time the risk is very much lessened.

To take in topics three and six under one head, namely, if the case is not operative, is there any treatment apart or combined with catheterization upon the subject of prostatism with hypertrophy?

It is impossible to separate these two for the very reason that the only justification of adopting a treatment other than catheter life or operation in hypertrophy of the prostate gland, is the fact that hypertrophy does not exist; that we do have a condition

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which I have diagnosed as prostatitis, in which there is a certain amount of irritation and congestion of the gland, without any increase in glandular and connective tissue elements, which in itself gives rise to very similar symptoms of the early stages of hypertrophy. Perhaps if anything, this condition carries with it more pronounced discomfort than the graver type.

Given, then, prostatism of this nature, what are we to do with it?

If we consider the fact that in the majority of instances this is due to an old gonorrhea, we shall come nearer appreciating the treatment which will be most efficacious. We will massage the prostate gland and use instillations of nitrate of silver, deposited in the membranous and prostate urethra. We will use, I say, instillations, not injections, and I wish you to consider this word instillation as spelled with capital letters. It is only a few drops that should be thrown in, and the strength of the solution should be varied according to the indications arising during the course of treatment.

It is rarely that irrigation of the bladder itself will be called for. I might say it is never called for, except as we may irrigate the whole urethral tract; in the milder type of cases, filling up the bladder only that we may get a second passing of the fluid over the area selected when the bladder is emptied.

Perhaps in this connection it will be well to touch upon the possibility of treatment in cases followed with cystitis, ureteritis and pyelitis.

Kelly, of Baltimore, in examination, at one time practiced washing out the ureters and the pelvis of the kidney through catheters passed clear to the renal pelvis. Few other surgeons have tried this method of procedure but, for the most part, however, have condemned it.

I cannot help believing that it is extremely dangerous, even in the most skillful hands, and certainly it is entirely out of the province of the average practitioner who possesses neither the equipment nor the training to even catheterize the ureters; con-

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sequently, in these severe cases we are practically limited in our treatment to vesical drainage alone.

4. Now if we have decided upon operation, how shall we proceed?

We have practically only three operative procedures before us, namely: Bottini, suprapubic, and the perineal. I purposely leave out what is known as the combined method, as being absoluely useless and dangerous in creating an unnecessary opening.

The Bottini operation has, I think, a place, but the limitations are very strict, and it requires a high amount of technical skill and training. It is adapted only to a very mild degree of hypertrophy, or perhaps I might better say to those cases which do not necessarily possess a true hypertrophy of the prostate, but only a stenosis of the vesical orifice, or what is known as the vesical bar. Its great advantages lie in the fact that generally anesthesia is not needed, that the patients are not confined to bed, or even, but for a short time, to the house, yet it is dangerous. It necessitates, also conditions which allow of a painstaking and minute cystoscopic examination. For the most part this operation has been again assigned to oblivion and will, I trust, remain there. With very few exceptions, it possessed no merits which are not equalled or surpassed by prostatectomy; its only virtue apparently consisting in adaptability to a very small number of cases wherein general anesthesia is absolutely contra-indicated, and any measure which may give relief is justifiable, short of electing actual operative death.

Certainly, the suprapubic operation has its uses.

Personally, I think that in those cases of badly infected bladders, in which the vital tone is very much lowered, that a suprapubic opening done at first only for drainage, and irrigation of the bladder, to be followed after an interval by an enucleation of the prostate gland through the same opening, is the only proper method of procedure in these cases.

We are told that the large, soft prostates are better removed through a superapubic opening; that the small fibroid prostates are better removed through the perineal opening. We are told

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by the advocates of suprapubic operation, that the urethra in part is better preserved by suprapubic operation. Yet on the other hand, within two years that party who popularized the suprapubic operation is now pleading for removal of the prostate gland *en masse,* together with the prostatic urethra, of course thus dropping one of his own arguments for the superiority of the suprapubic operation.

We are told that the operation is quicker and the drainage better by this route. I question very much if the operation is any quicker in uncomplicated cases. I question if drainage is not better or as good where the operation and the drainage are sought for at one and the same time in those cases which permit of doing the operation in one stage; certainly not where we are forced to operate in two stages.

For the perineal route which has been so strongly advocated by Young, it is said that we can see the parts as in any dissection. The same claim is made as for the superapubic route, that the drainage is better by the perineum. It is further claimed for the perineal operation that we can preserve ejaculatory ducts, and so preserve the potency of the patient. Now, as a matter of fact, I reserve for myself the same right in the election of the method of operation, as I would reserve for myself if I were practising medicine. If I were an internist and I knew of any drug which would benefit my patients, whether used by the homeopathist, or the eclectic, or the socalled "herb doctor," I should use it; in operating on the prostate gland, if it seems best to me to operate by the suprapubic route, I shall do so. If I elect the perineal it will be because I think that I can give the patient better prospects for an ultimate cure with less risk to life. I do not believe that it is necessary to make a minute and painstaking dissection of the perineum, nor attempt in the vast majority of cases to preserve the ejaculatory ducts.

Most of our cases are in men well past sixty, and at the time that they come to us these patients are impotent, not only as regards their powers of procreation, but as regards their power of sexual relation, and the conservation of these powers is a matter of absolute indifference.

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The median perineal incision, with opening of the membranous urethra, dilatation of the vesical neck and enucleation of the prostate masses through the lateral walls of the urethra can be done rapidly and thoroughly and will give one as perfect results as any other method of operation. There is rarely any hemorrhage, if we keep within the capsule, using the finger as a blunt dissector.

There are certain cases in which the relation between the capsule and the gland and the surrounding tissues is so intimate that enucleation as such cannot be accomplished. It is said that these cases can be better removed by *morcellement* than through a suprapubic opening.

This means rather a wide destruction of the vesical mucosa.

For my part, I think that these masses can be removed through the perineal incision, modified to give a broader exposure of the field, and it is in these cases that I believe in the technique of Young, using a tractor within the bladder, as causing less destruction of the bladder tissue than can be accomplished in any other way. It seems to me that the question of injury to the rectum has been very much magnified. If we use the exaggerated Trendelenburg position, with the thighs strongly flexed on the abdomen, we shall find that the rectum falls away very readily from the prostate. The only question of anatomy that I shall raise in any operation through the perineum will be to keep close to the bulb dividing the rectourethralis muscle and keeping outside the fascia of Denonvillier.

One thing which has run through the entire list of topics, if you notice, very much like a *motif* in music, although not named, has been the question of diagnosis. Beyond what has already been said of this, I am disposed to say a little something as regards the use of the cystoscope, and also touch upon the differential diagnosis.

There is one condition in which the cystoscope is of very great value; that is, where we have an enlarged middle lobe, with comparatively small amount of hypertrophy to be felt by rectal touch.

If we can get the instrument into the bladder at all, it gives us a very good view of the extent of this enlargement, and enables

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us to choose our methods of attack with reference to the ease of reaching the trouble. On the other hand, to use the cystoscope needs a large amount of special training, or the observations are not only not of value, but they are absolutely dangerous. These cystoscopes which depend upon air inflation of the bladder, and in which the opening for the prism is situated at the end of the tube, the so-called direct cystoscope, are of no use in this condition. We need a simple instrument with a prism on the concave side and water dilatation of the bladder. To use the instrument with any satisfaction, we must follow the procedure of Young, of Johns Hopkins, who has devised a scheme for reconstructing the inverted cystoscopic image and patching together the detached picture segments to give us a schematic representation of the whole field.

In the average case of prostatic hypertrophy the cystoscope is of no practical value. There is, however, one condition of the bladder as determined by the cystoscope, which justifies us in diagnosing prostatic hypertrophy without being able to feel same. I refer to the trabeculated bladder, which almost invariably is significant of enlarged prostate, with more or less urinary retention.

It is particularly important to differentiate hypertrophy of the prostate gland from new growths of the same, especially malignant disease; although in cancer we are told that hematuria is one of the symptoms, yet it occurs perhaps in not over twenty-five per cent of the cases.

In the early stages the most prominent symptom for differentiation is pain. The pain of cancer is much more severe than the pain of advenced hypertrophy, if such occurs; is sharper, more lancinating and very apt to radiate in the groin and down the leg. In fact this radiation, if we omit the coincidence of stone, is almost pathognomonic of cancer of prostate. A little later we get the stony hardness so significant of malignant disease. My records give me a total of eleven cases of malignant disease of the prostate, only one of which, so far as they have been followed, has shown hematuria. All but two have had severe pain; in fact that

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was the first symptom noticed by the patient, and for which he sought relief. The increase in size of the prostate had not been very marked prior to the onset of cachectic symptoms.

Manifestly it is important to exclude malignant disease before we decide upon operative measures, for with the one exception where the cancer is contained entirely within the capsule of the gland, operation is absolutely hopeless..

Then, too, simple hypertrophy of the prostate gland, or a congestive condition which has passed beyond the actual acute stage, calling as they do for two entirely different lines of treatment, should be carefully distinguished.

Retention of urine, difficulties in urination, in fact, practically all the symptoms that go with hypertrophy, are present in this congestive state. Even residual urine can be found, without the evidence, however, of any cystitis. This condition may persist for many weeks. Its treatment, however, is merely the employment of massage, instillations to the membranous and prostatic urethra; perhaps also enemata of hot water or the irrigation through a metal closed tube of hot water by way of the rectum.

Then, too, we should differentiate between a primary pyelonephritis, to which the cystitis is secondary in a man well past fifty, who in the natural order of events would possess a prostate gland which to the touch is more or less enlarged. Exclusive of the actual retention of urine, he may possess all the symptoms of the sufferer from prostatic hypertrophy, and only the most careful consideration of the previous history will help to establish the diagnosis; and it is in this type of case where operation for the prostatic trouble is practically almost always contra-indicated.

We cannot use a cystoscope to catheterize the ureter, on account of the dangers of increasing the infection and causing uremia; nor is it going to be of very great value should we succeed in securing the urine from one or both kidneys, for the reason that the whole question hinges on the fact of the infection being of an ascending or descending character. As regards the existence of stone in the bladder, the operation for relief of the hypertrophy of the gland will serve for the removal of the stone. In other words, there is a limit to the size of the stone which may

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be removed by way of the perineum. There is practically no limit to the size of the stone which may be removed by the suprapubic operation.

Abscess of the prostate gland may simulate acute prostatitis and, with the exception of tuberculosis and what is practically a chronic abscess, comes into conflict with the prostatic hypertrophy but very rarely. Save as in massive acute abscesses, I think that the ordinary prostatic abscess should be evacuated through a perineal incision and not by the old method of a curved trocar thrust into the abscess through the rectal wall or by incision through the rectal wall. Incision through the rectum is, however, I think justified in those large abscesses which pronouncedly bulge into the rectum, and often by pressure bring the rectal walls practically together.

Cysts of the gland require no especial mention. If large enough to give symptoms, they require evacuation and, of course, are better done through perineal incision. It is largely a matter of indifference whether we diagnose cyst of the prostate or hypertrophy of the prostate.

If we find a cyst we stop with our evacuation. If we find hypertrophy we simply proceed and enucleate the gland.

Tuberculosis of the prostate is rarely a primary disease, usually being secondary to tuberculosis of the testicle and seminal vesicles, and in those rare instances where we find it as a primary focus, its symptomatology will be largely that of abscess, either acute or chronic, and its treatment will be surgical only in so far as it is an abscess.

During the year, in the course of my office practice, I see a great many cases of chronic gonorrhea with all its complications, and I find that daily I am either examining or treating by massage several cases in which there is apparent enlargement of the prostate gland.

These cases, of course, are simple cases of prostatitis, and yet they are undoubtedly on the road which will bring them in later life to hypertrophy of the prostate. Coincident with these cases, and really the cause which keeps alive the prostatitis and the

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gonorrhea, is inflammation of the seminal vesicles, and it is really by the emptying of these vesicles, through massage, that we improve and cure the gonorrhea and, to a large extent, the prostatitis, although in long-standing cases it is my opinion that changes have taken place in the prostate from which the gland never recovers.

An analysis then of what I have said to you today resolves itself practically into the following: A plea for the education of the public as we meet members of it in our offices, in regard to the dangers of neglected prostatic hypertrophy. A plea for the earlier recognition by the physician and surgeon, and after a careful hearing of all the evidence, the advice to the patient of a much earlier operative interference than has heretofore been the custom, for the sake of cure of symptoms and conditions and the danger to life itself. A plea not to send the patient to a surgeon who elect, or to perform yourself, a suprapubic or a perineal operation without due regard for all the facts in the case, but to advise your patient, and so do yourself, that which shall be the best for the individual concerned, remembering that time in operative work is a very great feature, in the fact that it lessens anesthetic shock in a patient already on the downward path of life.

Of course it goes without comment that this saving of time shall not be at the expense of clean, smooth work, nor is it necessary on the other hand to exaggerate infinitesimal details.

There is no place in the surgery of today for either the putterer and bungler, or the man who is all "front," and gallery play, when dealing as we are with life, attempting to the best of knowledge and ability to keep it from fluttering into the "Great Beyond."—*The Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

Inguinal Hernia.

All evidence is in favor of the view that the main factor in the causation of inguinal hernia at all periods of life is the presence of a preformed sac, a patent funicular process, and whether the bowel will or will not enter this funicular process depends primarily upon the size of the opening at the internal abdominal ring, and, secondarily, upon the strength of the muscle guarding it.

As a general rule, the only satisfactory way of treating a hernia is by means of an operation; and, other things being equal, the earlier in life the operation is performed the better. The essential point in the operation is to so completely obliterate the sac as to render he peritoneal surface at this level free from any dimpling or depression. In order to do this, the inguinal canal should be opened up, and the divided aponeurosis of the external oblique subsequently united by overlapping, for the inguinal canal is thus lengthened and strengthened, and its original obliquity restored.—R. W. Murray in *The Monthly Cyclopedia of Practical Medicine.*

Incised Wound of the Liver.

Mr. Gaujet *Revue de Chirurgie,* August 10, 1907) presented to the Lyons Surgical Society a man who had received quite a large wound of the abdomen, with severe bleeding and extrusion of a small gut.

The blood came from the mesocolon, several vessels being ligated, from the liver and from an extensive cut of the gall bladder.

The cystic artery was first controlled; the liver had to be packed, both sutures and ligatures yielding. Recovery. A choleraghia, lasting only three days, appeared a month after the operation.

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Mr. Gangolphe believes that oftentimes it is wiser to tampon against hepatic hemorrhage. In a rapidly growing cancer of the liver, an incision made with the thermo-cautery determined a profuse flow of blood, which was stopped by a ligature *en masse*, including the abdominal wall and liver; gauze meshes had also been inserted in the wound, so that in reality tamponing, combined with forcible suture, was resorted to.—*N. O. Med. and Surg. Journal.*

Streptococcemia Accompanying Appendicitis.

David Sheitlis, of New York, reports a case of direct infection of the blood stream from a streptococus appendicitis. A loss of continuity of the mucous membrane of the appendix gives access for the streptococci which are normally present in the lumen of the intestines to the lymphatics and blood-vessels directly. If the protective function of the liver is not sufficient the germs pass through to the general circulation. In the author's case the constitutional manifestations obscured the local symptoms.—*Medical Record,* Nov. 2, 1907.

The Incision and Treatment of the Stump in Appendectomy.

Joseph B. Bissell, of New York, says that the incision in appendectomy should be of sufficient size to allow of the operative procedure, but should injure the structures of the abdominal wall as little as possible. Operative work should be rapid, so as to secure quick healing and a rapid convalescence. The author then discusses the best incision to be made use of in immediate, interval and late operations. The treatment of the stump is most important, as well as speed, the doing as little damage as possible to the tissues about the appendix, and the destruction of all infectious material, without leaving behind any material that may act as a foreign body. He describes the method of operation used by himself.—*Medical Record,* October 5, 1907.

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MEDICAL

Physical Therapy of Headache.

Reidel discusses a*Berliner Klinische Wochenschrift,* Vol. xliv., No. 20, Extract from *Journal American Medical Association,* September 14th, 1907) the physical means of controlling headache. In hyperemic headache there should be absolute rest, the head should have cold applications and to the lower extremities should be applied warm baths or friction. In headaches of anemic origin, place the head low, and massage the scalp. Hot compresses may be advantageously applied to the head and neck. Massage is particularly valuable for rheumatic or neuralgic headaches. The reviewer wishes to call attention to the value of Bier's hyperemia in the headaches from low blood pressure. This is not mentioned in the above article. A small rubber band about the neck will often act miraculously in aborting a headache, the result of indigestion or other factors that interfere with the circulation. A cotton bandage, a couple of inches in width, bound firmly about the neck, is, perhaps, the most satisfactory method of counteracting a lack of blood in the head.—*St. Louis Medical Review.*

A Case of Metal Poisoning or Intoxication.

Metol is a solution used by photographers for the development of pictures, and is usually employed when rapid development is the object. Patinet, a young man about nineteen years of age, or thereabouts, consulted me for pains in the shoulder and arm, and even the fingers. Diagnosis of rheumatism made and treatment instituted accordingly. Treatment proved of no avail. Pains continued for a fortnight, when patient went to the country on his holiday. Remained in the country for fifteen days, and during that period pains entirely disappeared. Returned to the city and once more pursued his usual vocation, that of photographer, when the pain in the shoulder, arms and fingers re-appeared. Pain became so intense that it was with difficulty that the patient could get out of bed. In an hour or two, and with vigorous rubbing

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of the affected parts, patient could use the arm and fingers. Anti-syphilitic treatment resorted to, and same proved valueless. My object in reporting this case is to secure some definite mode of treatment. Patient says he objects to giving up the trade of photography, as he will be left without a livelihood. How can this patient be treated and a cure affected and be still able to pursue his vocation. Upon investigation I have found four other photographers similarly afflicted. Do not know the composition of metol.—*N. O. Medical and Surgical Journal.*

Carbolic Acid Poisoning, Iodine In.

Three cases are reported which demonstrate the great value of iodine as an antidote for carbolic acid. In two of the cases the iodine was given early, before any general toxic symptoms developed, and acted most beneficially in relieving the burns of the mouth and throat. In the third case all the general toxic effects were fully developed, the abdomen being tympanitic and the stools dark and slimy; yet the patient recovered. In all the cases the iodine was given in the form of the tincture. The dose avries from a few drops to a drachm. The chemical compound formed as a result of the reaction between iodine and phenol is apparently harmless. For practical purposes, it is probable that equal parts of tincture of iodine and carbolic acid are complemental.—J. Maberly, *The Monthly C. of P. Med.*

Heart Disease and Blood Pressure.

Louis Faugeres Bishop, of New York, regards physiological re-education as of great value in the cure of functional cardiovascular disease. There must be persistent measures undertaken, covering weeks, months, or even a year; but excellent results may be obtained even where compensation is destroyed. The first thing to accomplish is relief from worry and mental concentration for the patient. Next comes reduction of diet, including taking away of the sweets and red meats. Exercise should be carried on systematically, whether the patient wants it or not, except in those cases in which failing compensation necessitates a short time in bed.—*Medical Record.*

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OBSTETRICAL

Simulating Tubal Pregnancies.

The author calls attention to conditions strongly simulating ectopic gestation, and leading to errors in diagnosis. These cases occur most frequently in young women who give a history of delay in menstruation. Suddenly they have pain and have a show of blood ordinarily of little quantity, but continuous and sometimes accompanied with clots.

The coincidence of an abdominal pain with uterine bleeding following a menstrual delay, is suggestive of ectopic gestation.

The uterus is not very large, but it may be larger than usual as the result of parenchymatous metritis.

In certain cases it is crowded upwards and to the front against the symphysis pubis. When due to a pyosalpinx, this condition will be explained by an exudate of periadnexal serous infiltration. Perhaps more frequently the uterus will be more or less fixed in its normal situation. If the patient is bleeding, the cervix may be slightly soft and the os patent.

In Douglas' sac a soft, elastic tumor is felt; sometimes quite voluminous and extending upwards laterally.

The breasts are not enlarged, the areolæ are not pigmented; Montgomery's tubercles are not visible.

There is neither nausea nor vomiting, although these are seldom marked in ectopic pregnancy. The predominating conditions, in short, are the delay in menstruation and the consecutive bleeding.

With the pain there is no evidence of internal hemorrhage. There is neither syncope, chills nor pallor. On the contrary, there usually is fever, which may last several days.

The masses in the pelvis strongly simulate hematocele, excepting that palpation may elicit pain. These masses quickly tend to harden. The previous history points to leucorrhea, labor, and especially artificial abortion.

Besides pyosalpinx, normal pregnancy complicated by other conditions may simulate ectopic pregnancy; also fibroid tumors,

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ovarian cysts with twisted pedicles and appendicitis.—*The Post Graduate.*

A Case of Spontaneous Gangrene of the Vagina.

The following case is reported by Asch *Monatschrift f. Geb. u. Gyn.,* June, 1907). A girl came into the hospital in December, 1906, five months after infection, who had been just one calendar month under treatment. The labia showed no morbid changes, the vagina was covered from the posterior commissure up to the cervix with a greasy, dirty-white deposit which could not be detached. The patient left the hospital, but was compelled to return within a month very much worse. The labia were red and swollen; the whole vaginal mucosa, separated from the vulvar tissue by a distinct line of demarcation, was black, sloughy and as hard as a board. Within a few days the gangrene extended into the bowel, and symptoms of cystitis developed, then peritonitis and evidence of general septicemia—in fact, the patient was dying when her case was reported. The gangrene seemed to be due to acute and rapidly diffuse parametric inflammation, cutting off all the vaginal supply of the vaginal wall, a process quite different from the slower changes not rare after lingering labors and fevers, where stenoses from cicatrization frequently develop. —*The Lancet-Clinic.*

Management of the Third Stage of Labor.

John W. Winston, of Norfolk, Va., considers the management of the third stage of labor as quite as important as that of the other two, since its proper conduct will result in a normal uterus, free from catarrhs and displacement. The removal of the placenta should take place promptly, so as to secure good contraction of the uterus. The uterus should be watched for an hour after its delivery, and removal should be facilitated by gentle friction, and, if necessary, by manual removal under antiseptic precautions. All tears should be repaired promptly under anesthesia. Hemorrhage should be attended to at once. Douching is not regarded by the author as essential. Ergot has value, but disadvantages as well. The binder is not regarded favorably.—*Medical Record,* October 12, 1907.

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

THE INTERNATIONAL CONGRESS ON TUBERCULOSIS.

Progress along all lines connected with the International Congress on Tuberculosis, which is to take place in Washington from September 21 to October 12, 1908, was shown by the reports presented at a meeting of the Committee on Arrangements, held in New York, at the Associated Charities Building, Monday evening, October 28. Dr. Lawrence F. Flick, of Philadelphia, Chairman of the Committee, presided, and the other members present were Dr. Joseph Walsh, Philadelphia, Secretary; Dr. John S. Fulton, Washington, Secretary-General; Mr. William H. Baldwin, Washington; Dr. Hermann M. Biggs, New York; Dr. Frank Billings, Chicago; Mr. Edward T. Devine, New York; Mr. Livingston Farrand, New York; Dr. J. C. Greenway, Greenwich, Conn.; Dr. Charles J. Hatfield, Philadelphia; Dr. Abraham Jacobi, New York; Dr. Alfred Meyer, Mrs. James E. Newcomb, New York; Gen. George M. Sternberg, Washington, and Dr. William H. Welch, Baltimore.

The meeting was the first held since Dr. Flick's return from abroad, and his reports of his visits to the International Conference on Tuberculosis in Vienna and to the International Congress on Hygiene and Demography, at Berlin, were interesting features of the session. More than a thousand delegates were registered at Vienna, he said, and the gathering at Berlin was quite as large. The leading men in both associations are looking forward with a great deal of enthusiasm, Dr. Flick said, to the meeting in Washington, next year, and about four hundred of the members of

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the foreign organizations may be expected to attend the Congress. The Conference selected this country as its place of meeting in 1908 just as the Congress did two years ago. The Conference and the Congress are two distinct organizations. The International Conference on Tuberculosis meets every year and keeps up a continuous organization with headquarters in Berlin. The International Congress on Tuberculosis meets only once in three years and does not maintain an international bureau in the intervals. Dr. Flick stated that at the International Conference, interest centered especially in the time-worn subject of the routes of invasion for the tubercle bacillus. It seems to have been demonstrated that the disease may be contracted by both the respiratory route, and the alimentary route. Though this does not make us much wiser in a practical way, still it is somewhat comforting to know that the respiratory route is less important than it was once thought to be. On the other hand that information is compensated by the importance of the alimentary route.

In connection with his account of the progress made in the preliminary arrangements for the International Congress on Tuberculosis, Dr. John S. Fulton, the Secretary-General, reported that ten distinguished foreigners have consented to participate in the series of special addresses that are to form a part of the program. The names of these eminent specialists follow: Dr. R. W. Philip, Edinburgh; Dr. C. Theodore Williams, London; Dr. Arthur Newsholme, Health Officer, Brighton, England; Dr. C. H. Spronck, Utrecht, Holland; Dr. Karl Turban, Davos-Platz, Switzerland; Dr. Gotthold Pannwitz, Charlottenburg; Dr. Emil von Behring, Marburg; Dr. A. Calmette, Pasteur Institute, Lisle, France; Dr. Maurice Letulle, Paris; and Dr. S. Kitasato, Tokyo, Japan.

Dr. Fulton also reported that up to the date of the meeting, the Governors of twenty-three States had lent official auspices to the Congress. This not only insures official representation so far as that many States are concerned, but it insures an active organization in each of these States, that will be interested in the Congress. The States in which this action has been taken so far are California, Utah, Montana, North Dakota, Minnesota, Wiscon-

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sin, Illinois, Iowa, Indiana, Michigan, Ohio, Kentucky, Kansas, Tennessee, South Carolina, North Carolina, Maryland, New York, Massachusetts, Vermont, Maine, West Virginia, Missouri.

Reporting on the formation of State committees, the Secretary-General said that such committees had been appointed in nearly all of the States in the United States; that several have already organized and are earnestly at work. He reported also that replies have been received from various foreign countries in reference to the appointment of committees, and the replies indicate that the countries addressed will be represented in nearly every instance by exhibits as well as by delegates.

American National Red Cross.

The following resolutions were adopted by the Executive Committee of the American National Red Cross, October 18, 1907:

WHEREAS, By international agreement in the Treaty of Geneva, 1864, and the revised Treaty of Geneva, 1906, "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross" were adopted to designate the personnel protected by this Convention; and

WHEREAS, The Treaty further provides (Article 23) that "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross can only be used whether in time of peace or war, to protect or designate sanitary formations and establishments, the personnel and material photected by this Convention;" and

WHEREAS, The American National Red Cross comes under the regulations of this Treaty according to Article 10, "volunteer aid Governments," such recognition and authority having been conferred upon the American National Red Cross in the charter granted by Congress, January 5, 1905, Section 2, "The corporation hereby created is designated as the organization which is authorized to act in matters of relief under said Treaty," and, furthermore,

WHEREAS, In the Revised Treaty of Geneva, 1906, in Article 27, it is provided that "the signatory powers whose legislation

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should not now be adequate, engage to take or recommend to their legislatures such measures as may be necessary to prevent the use by private persons or by societies other than those upon which this Convention confers the right thereto of the emblem or name of the Red Cross or Geneva Cross;"

Be it Resolved, That the Executive Committee of the American National Red Cross requests that all hospitals, health departments and like institutions kindly desist from the use of the Red Cross created for the special purpose mentioned above, and suggests that for it should be substituted some other insignia, such as a green St. Andrew's Cross on a white ground, to be named the "Hospital Cross," and used to designate all hospitals (save such as are under the Medical Departments of the Army and Navy, and the authorized volunteer aid society of the Government), all health departments and like institutions; and, further,

Be it Resolved, That the Executive Committee of the American National Red Cross likewise requests that all individuals or business firms and corporations who employ the Geneva Red Cross for business purposes, kindly desist from such use, gradually withdrawing its employment and substituting some other distinguishing mark.

Preliminary Program of the Southern Surgical and Gynecological Association, to be Held at the St. Charles Hotel, New Orleans, La., Dec. 17, 18, 19, 1907.

LIST OF PAPERS.

President's Address.

1. "Art Applied to Medicine and Surgery"—Dr. Howard A. Kelly, Baltimore.

2. "Art in Medicine" (by invitation—Dr. R. L. Dickinson, New York.

3. "Perinephritic Abscesses Following Parturition"—Dr. J. Shelton Horsly, Richmond.

4. "A Retroperitoneal Cystic Adenoma"—Dr. I. S. Stone, Washington.

5. "Post-Operative Complications in Abdominal Surgery"—Dr. C. M. Rosser, Dallas.

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6. "Post-Operative Complications of Peritonitis"—Dr. Randolph Winslow, Baltimore.

7. "Acute Dilatation of the Stomach as a Post-Operative Complication"—Dr. C. Jeff Miller, NeW Orleans.

8. "Surgical Treatment of Papilloma of the Bladder"—Dr. Charles H. Mayo, Rochester.

9. "Treatment of the Bladder after Supra-Pubic Cystotomy for Stone"—Dr. W. S. Goldsmith, Atlanta.

10. "Some Recent Factors in the Elucidation of Chronic Joint Disease"—Dr. C. E. Caldwell, Cincinnati.

11. "Treatment of Dislocation at the Shoulder Joint, Complicated by Fracture of the Upper Extremity of the Humerus"—Dr. J. M. Mason, Birmingham.

12. "Fracture of the Femur in Forcible Delivery with Presentation of a Splint"—Dr. Charles R. Robins, Richmond.

13. "Some Results of the Hodgen Splint Treatment of Fracture of the Thigh as Shown by the X-Ray"—Dr. George S. Brown, Birmingham.

14. "Practical Points in the Treatment of Fractures"—Dr. W. P. Carr, Washington.

15. Recent Advances in the Surgery of the Heart"—Dr. Rudolph Matas, New Orleans.

16. "Surgery of the Pleura"—Dr. John B. Murphy, Chicago.

17. "The Relaxed Knee-Joint and its Treatment"—Dr. Albert H. Frieberg, Cincinnati.

18. (*a*) "Tracheotomy for Foreign Bodies; Fifty-three Successful Cases; (*b*) Fracture of the Clavicle"—Dr. W. F. Westmoreland, Atlanta.

19. "Transperitoneal Ureterotomy"—Dr. Gerry R. Holden, Jacksonville.

20. "Is Catgut Preferable to Silk in Abdominal Surgery"—Dr. Joseph Tabor Johnson, Washington.

21. "The Treatment of Dislocation of the Shoulder Joint, Complicated by Fracture of the Upper Exeremity of the Humerus"—Dr. J. M. Mason, Birmingham.

22. "The Inconsistencies of the Gauze Pack"—Dr. H. A. Royster, Raleigh.

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23. "Abdominal Drainage"—Dr. P. F. Chambers, New York.

24. "Some Remote Symptoms and Effects of Cholelithiasis"—Dr. A. M. Cartledge, Louisville.

25. "The Treatment of Calculous Cholecystitis"—Dr. James N. Ellis, Atlanta.

26. "Some of the Reasons why Cholecystectomy should not be Performed so Frequently as at Present Advocated by Many Surgeons"—Dr. John B. Deaver, Philadelphia.

27. "Cyst of the Pancreas, with Report of an Operation and Exhibition of Specimen"—Dr. Rufus B. Hall, Cincinnati.

28. "The Management of Labor in Minor Degrees of Pelvic Contraction, with Special Reference to the Relative Indications for Abdominal Cæsarian Section. A Tabulated Report of 18 Cæsarian Sections"—Dr. Henry D. Fry, Washington.

29. "A Case of Sarcoma of the Rectum"—Dr. James E. Thompson, Galveston.

30. "Hare Lip and Cleft Palate"—Dr. Alexander High Ferguson, Chicago.

31. "The Diagnosis of Extra Uterine Pregnancy"—Dr. H. J. Boldt, New York.

32. "Floating Kidney Associated with Gastroptosis and its Treatment"—Dr. J. McF. Gaston, Atlanta.

33. "The Surgical Phases of Enteroptosis"—Dr. John G. Clark, Philadelphia.

34. "Further Notes on Harmful Involution of the Appendix"—Dr. Robert T. Morris, New York.

35. "Intestinal Obstruction Due to Thrombosis of Mesenteric Vessels, with a Discussion of the Differential Diagnosis of Acute Abdominal Lesions"—Dr. John C. Bloodgood, Baltimore.

36. "The Treatment of Diffuse Suppurative Peritonitis"—Dr. Stuart McGuire, Richmond.

37. "The Mechanism and Clinic of Pulmonary Embolism"—Drs. Willard Bartlett and R. L. Thompson, St. Louis.

38. "Leverage in Spinal Disease"—Dr. J. D. Bloom, New Orleans.

39. "Intramural Abscess of the Stomach"—Dr. J. Wesley Bovee, Washington.

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40. "Further Consideration of Operations for Cancer of the Head and Neck"—Dr. G. W. Crile, Cleveland.

41. (*a*) A Report of a Case of Inoperable Sarcoma of the Neck Cured by Use of Coley's Fluid; (*b*) The Complete History of a Case of Decapsulation of Both Kidneys for Chronic Parenchymatous Nephritis"—Dr. J. C. Oliver, Cincinnati.

42. "Giant Colon" (Hirshsprung's Disease)—Dr. J. M. T. Finney, Baltimore.

43. "Cases Illustrating the Value of Intestinal Exclusion as a Surgical Procedure"—Dr. John Young Brown, St. Louis.

44. "Report of Eight Consecutive Cases of Gunshot Wound of the Abdomen, with One Death"—Dr. LeGrand Guerry, Columbia.

45. "Choice of Time for Operation in Pelvic Inflammation of Tubal Origin"—Dr. F. F. Simpson, Pittsburg.

46. "Cœliac Parotitis"—Dr. Howard J. Williams, Macon.

47. "Suture of the Urethral Spincters for the Cure of Incontinence of Urine, with a Report of a Case"—Dr. Hugh H. Young, Baltimore.

48. Venous Thrombosis and Hydrocele of the Inguinal Canal" —Dr. Joseph Ransohoff, Cincinnati.

49. "A Remarkable Case of Hermaphrodism"—Dr. George Ben Johnson, Richmond.

50. "Report of an Interesting Case of Traumatic Epilepsy"—Dr. Denegre Martin, New Orleans.

51. "Nephrectomy for Hematuria of Pregnancy"—Dr. Edward A. Balloch, Washington.

52. "Report of a Case of Pyo-Nephrosis"—Dr. J. A. Goggans, Alexander City.

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Reviews and Book Notices

A Text-Book of The Practice of Medicine, For Students and Practitioners, by James Magoffin French, A.M., M.D., formerly Lecturer on the Theory and Practice of Medicine, Medical College of Ohio. Third Revised Edition; Illustrated by One Hundred and Ten Engravings in the Text, and Twenty-five Full Page Plates in Tints and Colors. New York. William Wood & Company. 1907.

The popularity of this well known book is amply illustrated by its appearance in its third edition so soon after the preceding edition. A large part of the text has been re-written and careful revision is apparent on every page. The work has been materially enlarged, and much new matter added. The most important changes have been made in the chapters on infectious diseases, the diseases due to animal parasites, and the diseases of the nervous system. Especial attention has been given to tropical diseases now being studied so carefully, and in which new and important developments are being made every day. It is an excellent text-book for students, being especially commendable for compactness, and at the same time thoroughness.

The Diagnosis and Treatment of Diseases of Women, by Harry Sturgeon Crossen, M. D., Clinical Professor of Gynecology, Washington University; Gynecologist to Washington University Hospital and Chief of the Gynecological Clinic; Associate Gynecologist, St. Louis Mullanphy Hospital; Consulting Gynecologist to Bethesda Hospital, St. Louis Female Hospital and St. Louis City Hospital; formerly Superintendent of the St. Louis Female Hospital; Fellow of the American Association of Obstetricians and Gynecologists; Ex-President of St. Louis Obstetrical and Gynecological Society; Member American Medical Association, Missouri State Medical Association, St. Louis Medical Society, etc. With Seven Hundred Illustrations. C. V. Mosby, Medical Book and Publishing Co., St. Louis. 1907.

This work is one of the very best of the kind presented to the profession recently, and deserves to become popular, for it is above all things most valuable as a guide to all needing assistance in the diagnosis and treatment of diseases of women. The

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work is thorough, comprehensive and systematic. The illustrations are well selected, many of them original and so numerous as to render any gynecological step clear. The text is concise, but clear and practical. We are highly pleased with the book, and cheerfully recommend it.

The Intestinal Secretions and the Principles of Medicine, by Charles E. De M. Sajous, M.D., Fellow of the College of Physicians of Philadelphia; Member of the American Philosophical Society, the Academy of Natural Sciences of Philadelphia, etc.; Knight of the Legion of Honor and Officer of the Academy of France; Knight of the Order of Leopold of Belgium, etc. Formerly Lecturer on Laryngology in Jefferson Medical College and Professor of Laryngology and Dean of the Faculty in the Medico-Chirurgical College; Formerly Professor of Anatomy and Physiology in the Wagner Institute of Science. Vol. II. With Twenty-five Illustrations. F. A. Davis Co., Publishers, Philadelphia. 1907.

A matter somewhat unusual is the long lapse of time that has intervened between the appearance of the first volume of this exhaustive work and the second volume, now before us. It represents, we may say, as would be impressed from the title, pioneer work, and furnishes a great deal of very valuable and interesting reading for physicians. The work is exhaustive and shows throughout laborious research on the part of the author, and scientific deductions of the greatest practical value.

Modern Clinical Medicine. Diseases of the Nervous System. Edited by Archibald Church, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence Northwestern University Medical Department, Chicago, Illinois. An Authorized Translation from "Die Deutsche Klinik," Under the General Editorial Supervision of Julius L. Salinger, M.D., with One Hundred and Ninety-five Illustrations in the Text, and Five Colored Plates. New York and London. D. Appleton & Co. 1908.

This is an excellent translation of the well known composite work of a number of eminent German neurologists. The articles on nervous diseases embraced in this volume meets the needs of the general practitioner in a most admirable manner. To the beginning practitioner to some extent the various articles supply the place of personal experiences and even to the specialist they furnish a most admirable resume and guide. The volume is

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well worthy of patronage and should be in the hands of every one at all interested in this most difficult subject.

A Text-book of Physiology. By Isaac Ott, A.M., M.D., Professor of Physiology in the Medico-Chirurgical College of Philadelphia. Second Revised Edition. Illustrated with 393 Half-tone Engravings, many in Colors. Royal Octavo, 815 pages. Bound in Extra Cloth. Price, $3.50 net. F. A. Davis Co., Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

Students of medicine should be especially pleased with this text-book of physiology, for it is pre-eminently ideal as such. In its second edition the work has been almost entirely re-written, numerous additions of most recently advanced views having been incorporated. Two hundred and fifty additional figures have been added which goes to show how improved the work is in this edition. We feel assured that this claimant for favor will rapidly take high rank among the popular medical text-books of the day.

Gall-stones and Diseases of the Bile-ducts, by J. Bland Sutton, F. R. C. S., Eng. Surgeon and Lecturer on Surgery to the Middlesex Hospital, etc., with Forty-seven Illustrations. New York. William Wood & Co. MDCCCCVII.

We are greatly pleased to have received this exceedingly useful little volume, for while advances in this especial branch of surgical work have been phenomenally great and the literature upon the subject has been excessively voluminous, this is the first attempt to crystalize in easily accessible form the accumulated experience of a number of years. The author is well known and his name alone is a guarantee of the high scientific value of the little book.

Visiting and Pocket Reference Book (Perpetual), 1908. J. H. Chambers & Co., Publishers, St. Louis, Mo. Revised and enlarged, handsomely vellum bound, lapel, pocket size. Price, 50 cents.

Condensed, at the same time sufficiently elaborate to give such information required in a book of this character. Convenient to carry in the pocket; containing 128 printed and blank pages.

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Synopsis of contents: Table of Signs; How to Keep Visiting List; Obstetrical Memoranda; Clinical Emergencies; Artificial Respiration; Poisons and Antidotes; Dose; Table; Important Incompatibles; Ruled printed pages for Weekly Visiting List; Memoranda; Nurses' Addresses; Clinical Record; Obstetric Record; Birth Record; Bills Rendered; Cash Received; Miscellaneous Memoranda; Death Record; Vaccination Record; Articles Loaned; Cash Loaned. The Publishers will mail copy postpaid on receipt of 24 2-cent stamps.

The Practitioners' Visiting List for 1908. An invaluable pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks. The 60-patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil and rubber, and calendar for two years. Price by mail, to any address, $1.25. Thumb-letter index, 25 cents extra. Descriptive circular showing the several styles sent on request. Lea Bros. & Co., Publishers, Philadelphia and New York.

Another physician's visiting list that deserves special commendation. It is in its twenty-second year of publication—a fact alone that attests its hold upon the profession.

The Physician's Visiting List (Lindsay & Blakiston's). For 1908. Fifty-seventh Year of its Publication. The Dose-Table Herein has been revised in accordance with the New U. S. Pharmacopœa (1905). Philadelphia. P. Blakiston's Son & Co., 1012 Walnut Street. Sold by all Booksellers and Druggists.

Our thanks are again due the accommodating publishers for a copy of this old standby of the practicing physician. In all the years that have elapsed since the date of first publication, this visitor has retained its popularity and is unexcelled for convenience.

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Publisher's Department

Rheumatic sore throat exhibits no exudate and no pus formation, but the membrane is a decided red, often rather dark, and is markedly aggravated by weather conditions that increase rheumatic symptoms. Local treatments and even the usually successful internal medicines for ordinary sore throat are inefficient. Tongaline or Tongaline and Lithia Tablets by rapidly expelling the poisons, which are the source of the complaint, will secure most beneficial results.

Stephentown, N. G.

The Anasarcin Chemical Co., Winchester, Tenn.

Gentlemen: In reply to yours of the 25th inst., will say the sample package of Anasarcin tablets was received. I gave them in a case of cirrhosis of the liver with ascites in which I had tried the usual remedies without any apparent effect. I had decided to tap the patient when my attention was called to your remedy, and although very skeptical about its being if any benefit, I gave it a trial. It "worked like a charm," entirely relieved the ascites and a month has now elapsed and there has been no return of the trouble. In the future I shall use your remedy in all cases of dropsy, for now I have great faith in it. Thanking you for the sample, I am Yours truly, C. A. CHALONER.

Troy, N. Y., Nov. 5, 1906.

The Anasarcin Chemical Co., Winchester, Tenn.

I received sample box of your Anasarcin Tablets and used them in my own family in a case of valvular disease, and renal stenosis. Such a pronounced localized edema of face on rising, and fingers; seldom in extremities or abdomen. Had used the usual remedies with no noticeable effect. Began with Anasarcin Tablets one hour before meals and on retiring. The result was most satisfactory, for on second day face and hands were normal and a better general condition of health has followed the continued use.

Elderly woman, fifty-six, had edema of feet, and ascites; mitral regurgitation. She was quite portly and I had little time or opportunity to examine heart; however, found her in the dis-

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tress of an attack of mitral regurgitation, followed by great agitation. Began the use of Tablets by crushing one and dissolving, giving solution of one every two hours. I was astonished at the rapid betterment of my patients.

I have secured the Tablets here in Troy, two boxes so far. I at first thought your literature rather strong, but now believe you are justified in all you claim. Very truly,

E. J. Fisk, M. D.

Relief in Rheumatoid Conditions.

Dr. Pettingill, of New York City, under the head of "Intestinal Antisepsis," reports some excellent experiences, from which the following is selected:

"Every physician knows full well the advantages to be derived from the use of antikamnia in very many diseases, but a number of them are still lacking a knowledge of the fact that antikamnia in combination with various remedies, has a peculiarly happy effect. Particularly is this the case when combined with salol. Salol is a most valuable remedy in many affections; and its usefulness seems to be enhanced by combining it with antikamnia. The rheumatoid conditions so often seen in various manifestations are wonderfully relieved by the use of this combination. After fevers, inflammation, etc., there frequently remain various painful and annoying conditions which may continue, namely, the severe headaches which occur after meningitis, a 'stitch in the side' following pleurisy, the precordial pain of pericarditis, and the painful stiffness of the joints which remain after a rheumatic attack—all these conditions are relieved by this combination called 'Antikamnia and Salol Tablets,' containing 2 1-2 grs. each of antikamnia and of salol, and the dose of which is one or two every two or three hours. They are also recommended highly in the treatment of cases of both acute and chronic systitis. The pain and burning is relieved to a marked degree. Salol neutralizes the uric acid and clears up the urine. This remedy is a reliable one in the treatment of diarrhœa, entero colitis, dysentery, etc. In dysentery, where there are bloody, slimy discharges, with tormina and tenesmus, a good dose of sulphate of magnesia, folqlowed by two antikamnia and salol tablets every three hours, will give results that are gratifying."

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

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PRESIDENT'S ADDRESS BEFORE THE ROBERTSON COUNTY MEDICAL SOCIETY.

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GENTLEMEN: Any man must feel complimented to be elected President of the Robertson County Medical Society. So many men, distinguished and honored, have filled this chair that it must be regarded with much dignity, and I, therefore, beg to return my heartfelt thanks to the members for this distinction having been placed on me.

Gentlemen, during our pilgrimage, there is but little allurement along the way; amid the scenes of suffering and death, where the black crepe and weeping willow are too often sad reliefs to the surroundings, is the path we have been pressing.

Every physician must feel impressed with the idea that he is a candidate for eminence. The words of the great men who have lived, flourished and passed away before us, seems to convince us that they carved their way to lasting honor through goodness and usefulness to their fellow-man. The distinguished success that crowned the efforts of our predecessors in their laborious task is, or ought to be, an exciting stimulus to every medical

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man; in this, as in all their services, there is room at the top. It has ever been a question of momentous import whether ambition should be commended or condemned; the reward should be, undoubtedly, commensurate with the motive; but in this, as in all things else, pertaining to worldly matters, we are taught by Sacred Writ to be temperate. Here, the analogy is plain and conclusion evident, that ambition in medical learning, as much as in law, philosophy or theology,, is worthy the highest encomiums when tempered by a desire to effect some good for one's fellow-being, but, hugged with a frantic delirium to eclipse all past generations regardless of the concomitant weal or woe, looking only to self-aggrandizement and intoxicated by flatteries of a senseless public, should be denounced and not be allowed to have a resting place in the conservatory of the eminently good and useful. But the mind of man, illumined with knowledge, naturally seeks freedom from restraint under the world's opinions, assumes the inherent right of its own observations, and from the myriads of theories, concordant and conflicting, lays down its own self-governing laws.

As science progresses and man becomes more sensible of the purposes for which nature showered her gifts so profusely, so does he realize the vital importance of carefully expending his time. Christianity, in its developed state, teaches us not to misapply the golden moments of our sojourn here; the great apostles well appreciated this doctrine when they began their mighty and glorious task, and behold what success! The world may well stand aghast at the grandeur of their victory.

The moral responsibility of the physician assumes, at times, the dimensions of the clergy, and many a grateful smile, the exponent of remembrance as lasting as life itself, will be added to his other emoluments.

In the early days of creation when the planets held their jubilee over the new-born world, and our forefathers basked in the golden languor of Eden's delightful clime, medicine had its beginning. Gathering strength in the onward march of time, and adding new votaries to its ranks in each successive generation, and finally shaking itself loose from the embrace of philosophy, it announced

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itself to the world an independent and self-sustaining science. Ever has its progress equaled that of its sister science, and it could always boast of as distinguished constituents as ever graced the ranks of any profession.

To give even a succinct compendium of medical history would encroach too much on your time; the subject is alluring and replete with interest to every medical man, but permit me here to introduce one familiar example—Hippocrates, the first, and may I not say the greatest architect in the medical structure, to whom the world delights to give honor, will ever live in the annals of time a benefactor to man, distinguished alike for his pioneering genius and Christian ventures; from his time to the present the world has never produced his superior, and we are almost tempted to say, his equal. In the midst of embarrassment that was threatening the young life of medicine, he triumphantly led the van and placed his darling study upon such a sound basis that the world's minions could not shake it with their witchcraft and sorcery; his opinions became accepted as oracles, not only in the school of medicine, but also in the courts of jurisprudence; his power was felt and recognized. In this connection, an introspection of medicine is always interesting to the physician; they feed largely upon the current books and periodicals. In the days of yore, and not so very long ago, books in medicine were not so very plentiful, and a complete list of authors who were usually recognized and regarded as authorities in medicine, was quite limited; consequently medical libraries were lean. Not so at the present time. Medical libraries are fat and full and overflowing with contributions from every country, which naturally leads an inquiry as to the man in medicine. A reply may be made that the man in medicine is, or ought to be, of great and persistent industry, with talents akin to genius, and does not hide them under a bushel or in a napkin, but as he works in a chosen field, make a record of his work.

Another thing, the man in medicine, besides being industrious, is a persistent attendant at medical society meetings; and he will, every time he is asked, confess, though it may be with reluctance, that his road was paved with the most uneven of works, hedged

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with thorns and brambles that were never done with their scratches and slashes, sometimes driving a bloody sweat from his brow, but all the same, there was no let up, the goal must be reached. It is always high with such men, as they know very well that a halt, if located on the side of the mount, will forever mean mediocrity; so the race goes on. Society meetings, papers and discussions must have no let up, in season and out of season.

It is an easy matter for any man to do an individual proposition, but it is the compound, comminuted and complex that indicates the timber of the aspirant for honors, emoluments and a place among the men of genius. Many a man starts out in a professional career with a laudable ambition stimulating him to do his best; his light for a time shines brilliantly; anon, it flickers and grows dim—perhaps going out, and a good man and physician is lost in the shuffle. The race is not alone to the swift, but to the one who has a gift of continuance with persistence to the end. It is so easy to be commonplace. The temptation is to continue in a direction of least resistance, where there takes place a folding of the hands and a satisfied air that denotes a falling out of the race; but I am persuaded of better things for the Robertson County Medical Society; we ought to know nothing of vacation and rest. Life is to live and labor on. Eventually we will be rewarded—it may be in old age.

May your meetings next year be characterized by love for each other as becomes physicians. May your future lives be full of happiness, and by the grace of God may we all meet again next year without the loss of a single one by the final summons, is the prayer and wish of your humble president.

Secret Commissions.

BY E. S. MC KEE, M.D., CINCINNATI.

Commission on prescriptions creep into notice once in awhile. We learn all the way from Delhi, India, through *Practical Medicine,* of that place, that a Wisconsin judge took the proper view of this practice, which, though rare, is doubtless done to a small

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extent. The ruling of the judge was that "any contract made between physicians and druggist whereby the former is to receive a commission from the latter for sending prescriptions to him, is illegal and against public policy."

A suspicion soon accrues to the physician who unduly urges his patients to take his prescriptions to one particular pharmacist, that he is being bribed to do so by a commission by the pharmacist. It has been rare that this has occurred in Cincinnati, but there have been a few such cases, and if we are to believe a widespread rumor there is one very flagrant case of this kind on hands now. An ophthalmologist who insists on his patients buying their glasses at a particular store lays himself open to the same suspicion. There have been very few cases of this kind in Cincinnati. It is true that a physician should direct his patients to take their prescriptions to the best pharmacists in his neighborhood, and the oculist should do the same with his prescriptions for glasses, but in large cities there are so many good dealers and pharmacists that limitations are unjust and unwise, and the good of the patient is not thereby served. Another scheme for biphebotomy is to prescribe under a number or name or cipher understood only by a certain druggist or dealer, with whom the physician is in collusion. The patient is thus obliged, no difference how disagreeable or difficult, to go to this particular pharmacist or dealer, under the impression that none other is capable or able to put it up properly, thus working an insulting injustice to other members of his calling. Sanitaria, mineral springs, proprietary medicine companies and such frequently offer physicians shares of stock on the business sent them as an inducement to the subscriber to take a more personal interest in furthering the sale of the goods.

Legislation against graft has been remarkably active in this country, as well as in England and Australia, of late. Judging from the Prevention of Corruption Act, which has been recently passed by the British Parliament, the giving and receiving of secret commissions must have been assumed to be a much more common practice than is generally admitted. For example, under this act, "medical practitioners must not receive commissions from tradespeople in return for recommending their wares; or from

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a dentist for recommending patients; nor are they allowed to pay commissions to hotel proprietors, lodging-house keepers, monthly nurses, midwives or others for introducing cases. A consultant must not share his fee with the medical attendant. Commissions may be paid to agencies for introducing resident patients, but no medical practitioner may be able to receive a commission for recommending a patient to a colleague, or to hotels, boarding-houses, lunatic asylums or sanatoria, or for any service where his whole duty is to his patient, from whom alone he should accept remuneration." We much prefer to believe that these provisions are more prospective than retrospective. We would be sorry to think that such practices were common enough to demand legislative action in our own country. In any case, they assume such a degree of degradation of a noble profession as is hard to conceive of.

It is even claimed by those in position to be well advised that certain hospitals offer inducements for bringing in patients, in the form of tips, lunches, solid and liquid, for police and patrol officers and other runners. The hospital, it is true, is the greatest grafter the doctor has to contend with when it comes to emergency or accident cases. It is difficult for the doctor to keep his own patients when injured from being hauled off to the hospital right under his nose by energetic squads of patrolmen. It has even happened in Cincinnati that they have endeavored to capture members of doctors' own families when injured and haul them off to the hospital, *nolens volens,* and only the most energetic protests prevented.

San Francisco suffered for the sin of commissions on prescriptions, as well as many others, at the great earthquake. The pharmaceutical press contained a statement of the bad conditions there, which, thinking them overdrawn, was sent to one of the prominent physicians in San Francisco with a query as to its truth. His reply was that there was only too much truth in it. He said that the doctors of San Francisco had in mind to fight the custom some day, but were too busy now with the patent-medicine fraud to take up further conflict.

The statement was to the effect that some years ago a drug-store was started in San Francisco, but, unfortunately, lost money

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from the beginning. After a time the proprietor packed up his stock, moved to New York City, and now has one of the most successful drug-stores in the Eastern metropolis. Why was the drug-store such a success in New York after proving such a failure in San Francisco? Here is the secret of the incident mentioned. The pharmacist whose business venture proved so unsuccessful was compelled to move from San Francisco because he refused to pay tribute to physicians for the privilege of filling their subscriptions. According to our authority on the matter, there was only one drug-store in San Francisco which does not give a percentage to some physician for every prescription filled.

Tribute is not only laid upon the pharmacist, but we are told that even the trained nurse must turn over to the physician the half of her first week's salary in each case in order to have her name placed on his list of eligibles. Even a divy was expected from the undertaker, it is said, if medical services proved unavailing. Comment on the state of morals in the medical and pharmaceutical profession of San Francisco is entirely unnecessary.

There is no doubt but that any contract between physician and druggist or other tradespeople whereby a commission is given or asked is illegal and against public policy. If a physician sends all his prescriptions to a neighboring drug-store and gets 15, 20 or 25 per cent on them, he will in all probability prescribe more often than is necessary, in greater dilutions and in doses of larger bulk. It is easy for the physician to make his prescription business four or eight times as profitable to the druggist as usual. Take for instance, Fowler's solution of arsenic, which costs wholesale about thirty cents a pint. Prescribe one ounce to go nicely in the vest-pocket and direct three drops three times a day. It will last nearly two months. Dilute this with water till the dose is a tablespoonful and an ounce bottle would hold two doses, a four-ounce bottle would not last three days. Note the difference in the cost to the patient if he took it in a month or two. I recall the case of a Cincinnati woman, whose husband makes ten dollars per week, who took her child to one of these commission doctors. Her medicine should have cost her a quarter or fifty cents. It did cost her three dollars for the one visit.

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Therapeutic Tips.

BY E. S. M'KEE, M.D., CINCINNATI, OHIO.

Hay Fever.—First thoroughly cleanse the parts with the following:

Cocaine hydrochlorate	1.00
Adrenalin, Adnephritin, seu Suprarenalin .....(1:1,000)	10.00
Atropinae Sulphatis	0.10
Sodii chloridii	0.75
Aquae destillatae ad	100.00

M. S.—Use as spray through the nose, then lie down for ten or fifteen minutes, allowing the remedy to reach all parts of the nose by the force of gravity. Repeat this three or four times a day.

Sodii chloridii	2.00
Sodii bicarbonatis	4.00
Phenolis	0.65
Carmine, q. s. ad color.	
Aquae destillatae	500.00

S.—Snuff through the nose.

Finish off with a 2-m mixture of chlorofrm in liquid petrolatum.

Lecithine.—A very easy method of preparing this remedy is as follows: Yolk of egg, rag, 300.00; distilled water, 60.00. Beat together and pass through a strainer and add glycerine, pure, 300.00; sodium chloride, 8.00; cherry laurel water, 10.00; syrup of lemon, 100.00; rum, 50.00. M. S.—Dose, two tablespoonsful three times a day.

Hydrogen Peroxide to Abort a Cold.—The inhalation of the vapors of hydrogen peroxide is recommended by Maget. These inhalations are repeated four or five times, and continue for five minutes at a sitting. The liquid must be in a boiling condition. If this be done over night, the patient will awaken in the morning free from every symptom of a cold. If the nostrils are plugged

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up with a secretion, apply adrenalin solution 1:10,000 a few minutes before the inhalation to clear the nasal passage. The treatment is excellent in chronic catarrh, if persisted in.

To Prevent Urethral Fever.—D. A. Freudenberg relates, in *Klinische Therapeutische Wochenschrift,* how for the last four years he has been using camphoric acid in powder in doses of one gramme three times a day, and also immediately before catheterization, and has had a complete abscence of urethral fever following the use of the catheter. The remedy, however, disturbs the stomach very much.

Sweating Scrotum.—For excessive sweating of the scrotum, accompanied by an odor, use a mixture of half an ounce of formaldehyde to a pint of water, and wash frequently with this. The solution may be increased till the sponging of the scrotum with pure formaldehyde can be tolerated, if necessary, though these stronger solutions are not often necessary. If there are any lesions from scratching, the stronger solutions should not be used. If desirable, use a powder after this application, consisting of orris root 30.00, salicylic acid 8.00, boric acid 30.00. This will protect the astringent effect.

Prickly Heat.—A very good remedy is a mixture of alcohol chloroform and ether equal parts, and menthol, 10 per cent. Alcohol alone is good, also equal parts of alcohol and spirits of camphor. Frequent changes of underclothing and repeated bathing are good, combined with avoidance of stimulating food and alcoholic drinks.

The Science of Doctor Bills.—The correct making out of bills, and the proper and successful collection of the same is the most scientific part of medicine. That our bills are large enough and not too large, little enough and not too little, that they work no hardship on the patient or on ourselves, or our confreres, that we charge as much as our patients can and will pay cheerfully and continue to employ us, and that we do not charge less than other doctors in our neighborhood, thus degrading medicine by underbidding—one of the most disgraceful of all things—to do

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all this properly, and to get what we want when we want or need it is scientific.

The doctor who enters the chamber of suffering at the hour of midnight, armed only with a pencil and a piece of paper is as unwise as the soldier who rushes to repell the midnight attack of the enemy leaving his arms and ammunition in his tent. Much valuable time, as well as prestige, is often lost by not having a few well picked remedies at hand. For the relief of pain, the checking of hemorrhage, the emptying of the stomach and bowels, and for heart affections, one should always be prepared. Some medicines, under some circumstances, are worth their weight in gold, if at hand. The general practitioner should neither dispense nor prescribe exclusively, but adhere to that happy medium—doing part of each, as best for both patient and himself.

Sir T. Lauder Brunton, in a recent contribution, states that he has found colds and respiratory diseases to so frequently follow the taking down of dusty books that he has resorted to sponging the edges with a solution of phenol before disturbing the deposit. The writer has one book in his library which never accumulates dust, and that is Brunton's "Materia Medica, Pharmacology and Therapeutics."

Dispensing physicians have more than once been the object of legislative attack, but the universal decision has always been that the right to furnish medicines to his patients is inherent in the physician, and that it is not probable that the legislature would deprive him of it, or that the court would sustain any such attempt, if made.

Naso Filter.—This is an ingenious instrument described by Heath, of Minneapolis, in the *Journal of the American Medical Association,* which consists of a German silver instrument consisting of two rings connected by a band. These rings are of such a size and shape as to fit into the nostril. They have spread over these rings a membrane of cloth which filters the air which is breathed through the nose, and retains irritating dust and pollens. The instrument is made for the use of hay fever suffer-

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ers, and persons who are obliged to work or exist in a dust-ladened atmosphere. The instrument can be easily inserted, removed and cleansed, and is quite a boon to those with a hyperesthetic Schneiderian membranes.

Non-Operative Treatment of Ingrowing Toe-Nail.—Sometimes the patient does not desire, and, in fact, will not permit of, an operation on an in-growing toe-nail. For these cases the *American Journal of Clinical Medicine* recommends the use of liquor potassae (U. S. P.) one part, and water four parts. Saturate a small piece of cotton with this and force it between the upper surface of the nail and the mass of tender granulation tissue. The alkali soon penetrates the substance of the nail without irritating the sore, but the cotton must be kept constantly moist to do the work well. The softened part of the nail is to be carefully wiped off every morning. In a few days the nail will have become so soft that it can be cut away without pain. The applications must, however, be continued till all granulations disappear and healing is well under way.

A Remedy for Dandruff and Falling Hair.—The remedy par excellence for this condition is, according to Dr. Franz Witlauer, *Monatshefte fuer Practische Dermatolgie,* surpassing even the much vaunted solution of salicylatic acid in alcohol, is a solution of camphor in alcohol: Camphor, 1 part; alcohol, 7 parts; water, 2 parts. Dissolve the camphor in the alcohol, and to the solution add the water. Use in an atomizer with a tube of considerable length. The end of the tube should be held against the scalp, thus moistening the hair but slightly, and wasting but little of the liquid. The cures are said to follow almost invariably and soon. The camphor odor, which is unpleasant to some, disappears. Witlauer does not ascribe its action to the antiseptic or disinfectant action of the camphorated spirit alone, but to the property of giving tenacity to the scalp alone.

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Selected Articles

Diagnosis of Gastric Cancer.

BY RICHARD F. CHASE, M.D., BOSTON.

Cancer of the stomach is a very common disease, more common than many realize. It causes about two per cent of the total mortality. Of all cancers, nearly fifty per cent involve the stomach. Statistics show that the disease is on the increase. In the writer's experience gastric cancer is encountered once in about every one hundred and fifty patients over fifteen years of age, as seen in a general medical clinic. If in such a clinic we should exclude the considerable number of patients under thirty years of age, we would then find the per cent of cancer patients vastly increased. Of a recent series of one hundred consecutive cases of gastro-intestinal diseases taken from private records, it was found that ten or ten per cent were cancer of the stomach.

The general physician who sees but one or two of these cases yearly rarely has the great seriousness of the subject brought home to him, as does the physician or surgeon who encounters fifty to one hundred or more cases each year. Yet it is upon the general physician that the welfare of these patients most depends, for it is he who first sees them and first directs their treatment.

Since there is no medical cure for the disease, and because surgery if taken advantage of early enough may bring about cures, an early diagnosis and resort to surgery is the accepted course to be taken.

But here the very important questions arise, "By what means and how early may the diagnosis be made?"

Medical means of diagnosis:

History—The symptoms arising from gastric cancer are usually of short duration at the time the patient first seeks treatment; rarely have they extended over a period of more than three to

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six months. Yet how often cancer has been excluded in the diagnosis, when present, because the patient may have had gastric symptoms for several years! In such cases of cancer, careful inquiry will almost always reveal the fact that the *character* of the symptoms or the *symptoms* themselves have recently changed. That is, the symptoms of a chronic "dyspepsia" have given place to those arising from cancer. Information regarding past ulcer should always be sought, because recent findings show that about fifty per cent (some say eighty and 90 per cent!) of cancer patients give a history of former ulcer.

Age—It is well known that the disease occurs most often between the ages of forty and seventy years, but cases occurring between the ages of thirty and forty years are by no means rare. In one of the writer's recent cancer patients, the disease occurred at the very early age of twenty-five years, eleven months. This case will warrant a further report.

Weight—It is equally well known that loss of weight is a very constant symptom. Just how constant and progressive, and of what diagnostic value this symptom is, will be shown in a measure by further reference to the ten cases already mentioned.

In eight of the cases at the time of their first visit there were losses of weight from three and one-half to forty-six pounds; in the other two cases there was extreme emaciation. But of *far greater* diagnostic value is the progress of weight during observation and modern medical treatment. Of the ten cases, six were observed and treated from four to fifty-two days, as may be noted in table. Each case during treatment, regardless of the great alleviation of symptoms in some cases, the increased diet and improved digestion, showed a loss of weight.

Occasionally, frequently perhaps, a maintenance or even slight increase in weight may be temporarily observed. But in gastric cancer this condition can be of but brief duration. Considerable alleviation of symptoms and increase of weight in the first ten days of treatment should not lead the physician to too early abandonment of the diagnosis of cancer.. Since a progressive loss of weight is rarely encountered during the treatment of gas-

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tric disorders other than cancer, its observation is strongly suggestive of a malignant condition.

By observing a patient's weight is meant the weighing of a patient at each visit on a set of accurate scales, due allowance being made for changes in clothing and other conditions influencing the weight. Of course more accurate information might be obtained by weighing the patient stripped, but this method has been found both impractical and unnecessary in office work.

The weight of patients with gastric cancer stasis should always be taken preferably after the stomach has been evacuated, and only such weights are to be compared.

The reason for this is that in cases of stasis, the contents of the fasting stomach may weigh from one to several pounds, hence after evacuation of the stomach, the patient weighs from one to several pounds less, depending, of course, on the amount of fasting contents. Not frequently loss of weight has been the chief factor in determining the probable presence of cancer; at other times, its continued absence has been the chief sign by which that disease was excluded. Let there be a more general use of this accurate diagnostic instrument, the weighing scales; then will cancer of the stomach be suspected at a much earlier stage of the disease, than at the present time.

If from the history, age, and loss of weight (enough points in any case to arouse suspicion) we suspect cancer, then by a thorough physical examination, together with the application of the various diagnostic tests at our command, we can soon strengthen or confirm our suspicions in the case of cancer, or prove their falsity in case of the existence of another condition.

Chemical Tests—The continued absence of Hcl and the *persistent* presence of lactic acid, when frequent gastric lavage is employed, are chemical abnormalities of the gastric juice most often met in cancer of the stomach, and very rarely in other conditions. These changes in the secretion are observed in most of the advanced cases of this disease, although with the lesion located at the cardiac end of the smomach, they may be met at a fairly early stage. On the other hand, usually in cases with the lesion at the pyloric end, the Hcl may be present in normal or

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even in excessive amounts, and as late as the last few weeks of the patient's life, but in these cases gastric stasis is almost always present and has probably existed for some time prior to this late stage.

The finding of food in the fasting stomach, at times when it should be empty, indicates either impaired peristalsis-stasis, or atony, or pyloric obstruction, conditions most often caused by cancer.

In the absence of gross signs of stasis, the finding of microscopic fragments of food in the rinsing water, several hours after the stomach has emptied itself, and especially if the lactic acid bacillus is present, is considered by Ziegler* an early and constant symptom of cancer.

Salomon's Test—The detection of appreciable amounts of albumin by Esbach's reagent, in salt solution which has been used to wash out the stomach, several hours after the stomach has emptied itself, according to Kuttner, Kirkelbach, and others, is a reliable and early sign of cancer. In a limited number of cases, the writer has thus far obtained positive results in cancer cases only, and negative results in mucous gastritis and other non-malignant diseases. The test seems worthy of further application.

Mechanical and Other Means—Very often aspiration of the stomach contents reveals the presence of free blood, and in cases in which hematemesis has never occurred. This finding, together with other symptoms, may suffice to practically confirm the diagnosis. The repeated detection of occult or invisible blood in the feces, if the proper precautions are taken in the tests, is a valuable diagnostic sign, and especially so in cases in which blood has not been otherwise observed.

Inability to pass a stomach tube more than fifteen to sixteen inches indicates an obstruction at the lower end of the esophagus or at the cardia; this condition with other signs may point strongly to a malignant disease.

Much delay or complete absence of the "deglutition sound" after taking a swallow of water also has the same significance. Simple palpation of the stomach, if skillfully carried out, will at

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times reveal the presence of very small tumors, even merely indurated areas on the anterior wall. And should doubt exist regarding the presence of a tumor, inflation and palpation may decide the question. Inflation and palpation is also one of the best means of locating certain gastric tumors, and of distinguishing between tumors of the stomach and of other organs.

Since the subjective symptoms of this disease are so closely simulated by those of other gastric disorders, they are of but little diagnostic value. Pain, however, of some variety is a very constant and fairly early symptom; so also is anorexia.

Numerous other tests of more or less value are sometimes employed in the diagnosis of this disease. However, the proper application of *all* the methods of diagnosis here mentioned will enable one to arrive at a reasonable certainty of the presence of gastric cancer, when present, much earlier than the diagnosis was formerly made; and in other non-malignant cases by the same means, one may exclude cancer in a reasonably short time.

Please remember that it is quite as important to exclude cencer in its absence as it is to make a positive diagnosis when present. The above methods are equally valuable in either case.

And, furthermore, let it be remembered, that the medical man's full duty to his suspected cancer patient has not been done until *all* of the medical means of diagnosis, if required, have been applied. The old cardinal symptoms of gastric cancer have been purposely omitted because if we are not to see patients until after the appearance of these symptoms, then there is little need of making a diagnosis.

If there are still some physicians who believe that a positive or negative diagnosis of cancer, as the case may be, can be made, simply by a chemical examination of the gastric juice, then the sooner they relieve themselves of this idea, the better it will be for all concerned.

There should no longer be occasion for the utterance of such laments as the following, recently made by one of our prominent surgeons: "It has been pathetic, in some cases, to have patients withheld from operation by supposed absence of cancer, because of the presence of Hcl" (in the gastric juice).

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The value of the laboratory methods of diagnosis has at times been overestimated by physicians, and underestimated by some surgeons. It should be remembered by both physicians and surgeons, that of our medical means of diagnosis, the laboratory tests constitute but a *part*. As is well known, most surgeons advocate surgical exploration as the best means of making an early diagnosis of cancer.

There may be some surgeons who believe, even as John B. Deaver does, that "no patient who presents symptoms of chronic gastric dyspepsia should be allowed to go on his way without operation, as a preventive of malignant disease." But William J. Mayo, who advocates and is as prompt in carrying out early exploration as are most surgeons, says of the diagnosis of cancer: "The most careful and painstaking methods of examination, including laboratory tests, should be insisted upon, but they should not be unduly prolonged."

It can be most truthfully stated that if Mayo's advice is heeded, there will be much needless gastric surgery, and far more cancer patients will be forthcoming, at a stage of the disease warranting a greater number of radical operations. But in this work there must be intelligent and prompt co-operation on the part of the general physician, for it is he whom the patient first consults, and it is during these early visits that the true condition must be suspected, and determined by some means within a very short time.

We are now confronted with the highly important question, "How much time may be allowed for the carying out of the medical means of diagnosis?" Of course, no rule can be established for all cases, except the general one, that it must be as short as possible. In advanced conditions the diagnosis may often be made with much certainty at the first or second visit. At this time a radical, in fact any, operation is usually out of the question. In selected cases a palliative operation may prove of some benefit. In earlier cases, two or three examinations in as many days or a week's time may be necessary. At this stage of the disease occasionally a condition will be found which warrants a radical operation, or, failing in this, if the lesion is at the pylorus.

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a gastro-enterostomy may prolong the patient's life several months.

In a still earlier class of cases, two or three weeks' time may be required to reach a probable diagnosis, or to learn that the patient needs surgical attention. In quite a number of these cases, if the lesion is favorably located, that is, in the pyloric end, and metastases are not too extensive, resection may be done, or, with adverse conditions for resection, the physician should know at least, and prior to the incision, that a gastro-enterostomy is probably indicated. The chief points to be observed in these various classes of cancer regarding operations are: (1) that the physician should be reasonable certain of the presence of cancer; (2) he should usually know when the case is beyond surgical relief; (3) in cases which he considers operable, he should have a pretty good idea that the conditions warrant at least a palliative, perhaps a radical, operation. Ulcer cases with stasis may be included here. Some of them cannot be differentiated from cancer by medical means; (4) in certain cases, either early or late, he should know if the cancer is located at the cardia, or lower end of the esophagus, and be aware that no operation, except a gastrotomy as a last resort, should be attempted. In advising regarding operation, the patient's age and his physical condition are features which should be duly considered.

The above classes of patients (and Hoffmann figures it that the disease has then been present ten and three-tenths months) constitute the vast majority, perhaps 95 per cent, of all gastric cancers as seen by the consultant.

In the remaining small portion of cancer cases, the true conditions perhaps cannot be learned by medical means within three weeks' time. In most of these cases, perhaps all, a surgical exploration should certainly be made, and the operation carried out which seems indicated. But even in these cases a radical operation cannot be done, unless the lesion is favorably located. Sometimes the surgical diagnosis will be negative and sometimes mistakes will be made. Mistakes are also made by the medical man. Thus far those of the writer have been in the nature of commissions rather than omissions. They have resulted from one

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chief cause, lack of sufficiently close and long observation of the patients. In private practice this lack of observation has occurred only in those cases in which it was felt that the physician, referring the case, expected a positive or negative diagnosis from a *single* examination. This source of error in diagnosis has now been eliminated.

If a physician desires a tolerably accurate diagnosis and the best advice from the consultant, he should turn over his patient absolutely, until such time as is required for the final report. Sometimes three days, at other times three weeks, might be required for this report, but not a longer period. A reasonable length of time must be granted for the carrying out of the various tests. In some cases more time may be required to exclude cancer than is needed in other cases to make a positive diagnosis.

For example, at the first visit an absence of Hcl, and other symptoms may point to cancer, yet one or two weeks' observation and proper treatment may show, by a return of the Hcl, that the case was one of chronic gastritis or simple achlorhydria. Had the case proven to be cancer the diagnosis might have been made in shorter time.

In conclusion, it may well be stated that cancer of the stomach should *more often* be thought of by the physician in his diagnosis of gastric disorders, and at an earlier stage of the disease. It is to him that the choice of methods of diagnosis is necessarily left.—*Boston Medical and Surgical Journal.*

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Extracts from Home and Foreign Journals.

SURGICAL

On Perianal and Perirectal Abscess.

Charles B. Kelsey, of New York, says that the perirectal and perianal space is peculiarly subject to injuries and diseases which create a favorable site of attack for bacteria. The germ of tuberculosis is the one that most frequently attacks the rectum. The explanation of this fact is the profuse lymphatic supply of this region, and a lesion of the rectal or anal mucosa may cause an abscess at a considerable distance. Abcesses in the perirectal space should not be confounded with those in the cellular tissue behind the rectum. Diffuse pelvic cellulitis may involve all the cellular tissue under the peritoneum of the pelvis. It is the most frequent cause of death after extensive rectal operations. Gangrenous periproctitis is also fatal, but very rare. It is due to some virulent poison. Diseases of the urinary organs, of the pelvic bones, of the female pelvic organs, stricture and cancer of the rectum, and abscesses in Bartholin's glands may all cause pelvic abscesses which burrow extensively. Marginal, follicular, and thrombotic abscesses of the anus are common, but simple. The general rule of treatment is early and free incision.—*Medical Record.*

The Surgical Treatment of Nephrolithiasis.

Dr. Perthes (Medical Society of Leipsic) considers operation indicated in renal lithiasis under the following circumstances: 1. Anuria in consequence of obstruction of the ureter by the calculus, if of more than forty-eight hours' duration. 2. Purulent infection of the renal pelves and acute and chronic pyelitis and pyelonephritis. 3. Retention due to obstruction by renal and ureteral calculi (hydronephrosis and pyelonephrosis). 4. Exhausting hemorrhages. In his opinion the operation of choice is nephrolithotomy. In cases of advanced pyelonephritis and when the other kidney has been shown to be healthy, as well as in hydrone-

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phrosis and pyonephrosis with comparatively thin walls, nephrectomy is to be preferred to nephrotomy. In aseptic and uncomplicated cases of renal calculi the indications are less positive. According to Perthes, these are especially determined by radiography. Stones of the size of a pea, or larger, the presence of which can nowadays be determined by X-ray examination, cannot pass through the ureter, or if so, only with risk. If allowed to remain in the renal pelvis they may give rise to future complications, the danger from which is greater than from an aseptic nephrotomy. He therefore recommends surgical intervention during the aseptic stage, and cautions against delay until the appearance of urgent complications. After the renal pelvis has become infected the mortality of the operation is at least doubly as high as in the aseptic stage, and moreover it is only in a certain proportion of cases that conservative methods can then be employed. For these reasons operation should be resorted to in every case in which Roentgen examination shows a renal or ureteral calculus of the size of a pea or larger, provided that the general condition is favorable.—*International Journal of Surgery.*

The Relationship of Trauma to Insanity.

Arthur Conklin Brush, of Brooklyn, believes that trauma has seldom any relation to insanity, and that to substantiate such a claim it is necessary that the mental symptoms should immediately follow the injury and marked brain injury be evident. The existence of a neuropathic heredity, alcoholism, or syphilis is more often the real cause of the insanity than the supposed injury. One form of insanity is caused by injury; this is primary traumatic insanity, resulting from acute encephalitis. Contusions about the fourth ventricle, and the tips of the frontal and temporal lobes are the causes of the encephalitis. Meningeal hemorrhage is also common. In healthy brains these lesions may disappear, while encephalitis will result in diseased ones. Insanity must immediately follow the cerebral contusion. The invasion of the psychosis is rapid, but not sudden. The patient is excited, sleepless, or somnolent alternately. His mood varies,

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and he is anxiously depressed, or excitable. Mental confusion and loss of memory are prominent symptoms. Tremor of face and hands, paralysis, increased reflexes, and ataxia may be present. The duration varies, being under two years as a rule.—*Medical Record.*

MEDICAL

Obesity, Gout and Diabetes.

Ebstein groups these three diseases in one class, as heredity diseases of cell metabolism. Obesity appears to be due to a deficiency of cell activity, rendering the subject unable to consume in the same degree as is the case with non-corpulent persons, the fatty acids that appear in their immediate metabolic processes. Gout depends on the disturbance in an intermediate state of metabolism, namely that of the nucleins, and this, too, is due to a hereditary tendency. In diabetes we find an anomaly of carbohydrate metabolism—dextrin and other sugars, acetone, acetic acid, and B-oxybutyric acid, which are completely destroyed in the healthy organisms, appearing in the urine. There is a diminished excretion of carbonic acid gas, a property of which Ebstein considers to be the retarding of the action of the diastatic enzymes, which makes it the regulator of the formation of sugar from the glycogen stored up in the biogens. When the action of the diastatic enzymes is insufficiently regulated, because there is lack of carbonic acid in the presence of the diminished internal respiration, the almost indiffusible glycogen is more rapidly transformed into the extremely diffusible sugar, which thereupon appears immediately in the body fluids and then in the urine; so that Ebstein thinks that the glycosuria in diabetes is due to the fact that the sugar present, or formed during the intermediate steps of metabolism, is more or less completely excreted before it can be assimilated by the whole organism. He does not regard diabetes mellitus as a symptom of the disease of various organs, but as a disease *sui generis*, the first cause of which lies in a de-

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ficient character of the protoplasm, that is, transmissible by inheritance.—*Journal of American Medical Association.*

Diseases of the Gastrointestinal Tract on the Borderland Between Surgery and Internal Medicine.

John C. Hemmeter, of Baltimore, considers the early diagnosis of cancer of the intestine. It is hardly possible in the latent stage and one of the difficulties of the surgeon is the late stage of the disease at which the patient consults him. A serum diagnosis of such pathological conditions is more desirable. The author gives his experience in differentiating the different forms of tuberculous peritonitis. There are three valuable aids in diagnosis. The first is intraperitoneal injection of some of the exudate in guinea pigs. The second is the injection of tuberculin. The last is the diazo reaction. This reaction occurring repeatedly indicates a tuberculous condition. The author believes that a cure of tuberculous peritonitis is possible aside from operative interference. His experience leads him to believe that at least as many patients recover under conservative medical treatment as under operation. Peptic ulcer of the duodenum and jejunum following gastroenterostomy for benign stomach diseases is a result of faulty conditions preceding and following operation. The acid chyme of the stomach should pass the orifices of the bile and pancreatic ducts, and the degree of stomach acidity should not exceed two parts to one thousand. Care must be taken to establish a proper course for the food such as nature intended it should take. Otherwise a duodenal ulcer may develop. A purely medical and dietetic treatment should be tried for a long time before operation takes place.—*Medical Record.*

A Consideration of the Causes and Characteristics of the Weak Foot.

Royal Whitman, New York, brings forward a theory of the causation of weak foot, which will account for the discomfort without deformity that is often found in this condition, and a treatment that is applicable to the prevention of the condition

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before advanced distortion has occurred. There are two contrasting postures of the foot, that of activity and that of inactivity. In activity the foot is incurved at the inner border and the arch is accentuated. In inactivity the foot is everted and the weight is directed toward the inner side of the sole. The abnormal persistence of the attitude of inactivity during exercise produces deformity. Abduction is caused by inward rotation of the leg upon the foot, and the astragalus supporting the leg sinks downward and inward upon the os calcis. Acquired flat foot and weak foot are an abnormal persistence of the attitude of abduction. The primary factor is the abduction, the secondary is the lowering of the arch. The symptoms are due to overstrain and injury to which disordered function has exposed the foot. Predisposing causes are insufficient support, due to congenital or acquired weakness of structure; weakness of muscles; overweight or strain, and improper attitudes, that is imperfect adjustment. Improper attitudes include toeing out, the most important bad attitude. Improper shoes are often worn. Rachitis is a cause of weakness of structure. Symptoms include bad attitude, weakness, pain in feet, knees, and even back, and deformity, with muscular spasm. Preventive treatment includes proper shoes and proper attitudes for children. Shoes should turn in. The brace used is made on an accurate plaster model made with the foot resting upon the outer border, slightly plantarflexed, and perpendicular to the table. The brace is of sheet steel extending from the bearing surface of the heel to the metatarsal bone. It is placed in the shoe, and the inner flange is pressed against the arch in positions of strain. It should hold the foot in place without discomfort. The inner side of the shoe is raised. Deformity may need to be corrected with or without anesthesia.—*Medical Record,* August 31, 1907.

The Practical Uses of Venesection.

Mendel shows that venesection, once so much abused, has been neglected for many years, and says that there are many conditions where it is of great value. The indications for using venesection are as follows: I. Disturbances in the corpuscles of

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the blood: (1) Poisoning by illuminating gas. It removes the poisonous compounds formed by the gas in the blood, which do not allow the CO_2 to be thrown off and lead to asphyxiation. (2) In uremia and eclampsia it gets rid of products of the toxic metabolism which are circulating in the blood. (3) In gout, during the acute attack, the author has used blood-letting with excellent results, the patients often remaining free from attacks for long periods after the blood-letting. The single attack always clears up more quickly with venesection than without. (4) In chloroses Mendel does not agree with certain other authors that venesection is of value. II. Disturbances of circulation: (1) In cerebral apoplexy the author recommends venesection in all cases, whether the blood pressure is high or not. He has used it in cerebral hemorrhage with good effect. (2) The author strongly recommends bleeding in all cases where the right heart is overloaded and dilated, as in valvular disease and myocarditis with broken compensation and acute dilatation; also in pneumonia where the right heart is overloaded.—*Boston Medical and Surgical Journal.*

OBSTETRICAL

Quinine in Labor.

Dr. Conitzer reports his results with quinine in 66 cases of labor, 22 of which were normal. Of 39 cases of abortion and premature deliveries, the quinine failed in 13. In 13 cases the quinine alone was sufficient to bring the abortion to a successful end. The dose of the quinine was from 8 to 15 grains per single dose, the total dose being from 15 to 45 grains. The effect was often noticeable after ten minutes, but generally only after the second or third dose. When the quinine does act, it increases the pains, makes them stronger, of longer duration and without any bad effects for mother or child. The author has not noticed that the quinine had any tendency to increase hemorrhage.—*Therapeutic Medicine.*

Treatment of Postpartum Hemorrhage.

In cases of postpartum hemorrhage due to atony of the uterus, Stowe has tried with great satisfaction a method of hemostasis,

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which he has not seen mentioned in literature. In several instances he has been able to arrest completely a profuse hemorrhage. A sterile towel should be placed over the abdomen, or if this is not at hand, a laundered towel, soaked with a 1 to 1,000 solution of corrosive sublimate, acts as a good substitute. Now the external hand grasps and firmly kneads the fundus and presses it down into the inlet. The other hand, incased in a sterile glove, is passed into the vagina up to the cervix. The fingers then attempt to seize as much of the cervix and lower uterine segment as possible, and the hand is forced far into Bandl's ring until the fundus is reached. The internal hand remains outside the uterine cavity throughout the operation. If sufficient pressure be used the internal hand can be forced well into the fundus and past the contraction ring, pushing the cervix and lower uterine segment before it against the walls of the fundus. This obliterates the cavity of the uterus, and brings direct pressure and compression to bear against the sinuses and open vessels. The position of the internal hand or fist in the fundus, yet outside the uterus, has a marked effect in stimulating contraction, especially when aided by brisk massage.—*Jour. A. M. A.*

Some Aspects of Sterility and Its Treatment.

A. J. Ronginsky, of New York, believes that in sterility the male plays an important part. It may result from masturbation, excessive coition, want of sexual affinity, mental fatigue, congenitally small penis, or varicocele; finally it is necessary to examine several specimens of semen and ascertain that the spermatozoa are absolutely normal. In the woman there may be general muscular relaxation, lack of function on account of age, or excess of sexual excitability. Of organic changes we may enumerate almost all the gynecological troubles. The principal are congenital lack of development of some part of the genital tract, leucorrhea, stenosis, and gonorrheal tube affections. The author discards infantile uterus as a cause. Appropriate remedies are suggested for each of these conditions. In conclusion he exhorts the physician to education of the public to the knowledge of the baneful effects of gonorrhea on the fertility of the sexual organe.—*Medical Record.*

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Editorial

PUBLISHER'S NOTICE.—The JOURNAL is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business Manager, S. S. Briggs, M. D., corner Summer and Union Streets, Nashville, Tenn.

All communications for the JOURNAL, books for review, exchanges, etc., should be addressed to the Editor.

A WORD OF RETROSPECT AND A WORD OF GREETING.

With the present number of the Journal, we enter upon the 57th year of its existence, and in looking back over its long journalistic life we are struck with the momentous changes and wonderful advances made in medical science since its inception. The wonderful development of science as manifested in the practical reduction of electricity to the every day use of man, as in electric motors, the telephone, electric illumination, the phonograph, etc., the wireless telegraph, and other discoveries, have been paralleled by as phenomenally great advances in the domain of medicine and surgery as evinced in aseptic surgery, the wonderful achievements under that discovery of surgery in operations upon every part of the human system, in the development of the X-ray, in the discoveries of bacteriology, in the serum treatment of disease, in the opsonin theories now being put to practical use, in the discovery of the potent properties of radium, in the teaching of the causes of yellow fever and in the application of these theories to the prevention of epidemics, etc. Space is too limited to refer even briefly to the stupendous changes that have been wrought in the 56 years that have passed since the organization of this Journal. Established in 1851 by Dr. W. K. Bowling, and conducted by him during his life with most brilliant and wonderful success, the Nashville Journal of Medicine and Surgery became the principal exponent of Southern medical literature. Following the founder at varying intervals as editors were Paul F. Eve,

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W. L. Nichol, John H. Callender, W. T. Briggs, Thos. O. Summers, all noted names in the annals of Southern medicine and surgery. For nearly a quarter of a century the present editor has been at the helm and he has through all these years endeavored most earnestly and zealously to keep the Journal up to the high standard made for it by his predecessors. For the support and patronage accorded him by the profession of the South during that time he is warmly grateful, and he earnestly bespeaks a continuance of the same for the future. He appeals to the readers of the Journal for material as well as moral support, and just here would take occasion to say that certain obligations exist between reader and publisher which we regret to say has of late fallen into "innocuous desuetude," on the part of the former, and that many subscribers have of late utterly ignored the fact that their subscriptions have in many instances been unpaid. The editor therefore asks that every subscriber begin the new year by sending in the money he owes, or at least inform him as to his intentions. We hope to continue to publish the Journal, but we must ask the help of our friends to enable us to do so. We wish all our readers a Happy Christmas and a Prosperous New Year, and in the language of Tiny Tim, immortalized by Charles Dickens in his Christmas Carols, say, "God bless us every one."

Alexander Mactier Pirrie.

A MARTYR TO SCIENCE.

A career of great promise has been cut short by the untimely death of Mr. A. Mactier Pirrie. The son of the late Mr. Alexander Pirrie, C.E., he was born on October 2, 1882. He obtained his B.Sc. with honors in anthropology at Edinburgh University in 1904, and qualified as M.B., Ch.B., in 1906. He obtained the Carnegie Research Fellowship in anthropology and was appointed anthropologist to the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum. He went out to the Sudan in the autumn of 1906. Under the direction of Dr. Andrew Balfour, the director of the laboratories, Dr. Pirrie made his first

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expedition up the Nile to the southern limits of the Sudan, and penetrated to remote parts of the Bahr-el-Ghazel. His second expedition took him to the borders of Abyssinia. On both occasions he passed through some of the most pestilential regions of Africa in connection with certain anthropological and physiological researches, appertaining to tropical diseases, upon which the laboratories are engaged. Unfortunately he contracted tropical fever (kala azaar), and was so prostrated as to be compelled to return to England, leaving Khartoum on June 17 last. He rallied from the effects of the fever from time to time, but was compelled to enter Chalmers' Hospital, Edinburgh, in October. His death took place on November 12. He was interred at the Dean Cemetery, Edinburgh, on November 15. The Gordon Memorial College, Khartoum, Sir William Turner, Principal and Vice-Chancellor of the Edinburgh University, Mr. Wellcome and others, were represented, and sent wreaths. A resolution of sympathy has been conveyed to the relatives from the trustees of the Gordon Memorial College, and other expressions of sympathy have been received from the Liverpool School of Tropical Medicine, etc. It is of interest to note that the first case of kala azar found in Africa, except a case in Tunis referred to by Laveran, was reported by Dr. Sheffield Neave, pathologist to the Wellcome Research Laboratories, Khartoum. Dr. Neave found the Leishman-Donovan body, the parasite of kala azar, in the splenic blood of a patient in the Omburman Civil Hospital. The discovery is noted by the director in the second report of the laboratories. Dr. Pirrie presented a paper on his African expeditions at the last meeting of the British Association for the Advancement of Science, but was prevented from being present on account of his illness. He brought back a most valuable collection of objects of scientific interest. At intervals during his illness he was engaged on his report to the Carnegie Institute and the Wellcome Research Laboratories, Khartoum, for which institutions he acted jointly in the important work he carried out in the Sudan. (Reprinted from the *"British and Colonial Druggist,"* Nov. 22, 1907.)

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PHYSICIAN (MALE). INDIAN SERVICE.

The United States Civil Service Commission announces an examination on January 15, 1908, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill vacancies as they may occur in the position of physician (male) in the Indian Service, at salaries ranging from $720 to $1,200 per annum.

The examination will consist of the subjects mentioned below, weighted as indicated:

Subjects.	*Weights.*
1. Letter-writing (the subject-matter on a topic relative to the practice of medicine)	5
2. Anatomy and physiology (general questions on anatomy and histologic or minute anatomy)	10
3. Chemistry, materia medica, and therapeutics (elementary questions in inorganic and organic chemistry; the physiologic action and uses and doses of drugs)	15
4. Surgery and surgical pathology (general surgery, surgical diagnosis; the pathology of surgical diseases)	20
5. General pathology and practice (the symptomatology, etiology, diagnosis, pathology, and treatment of disease)	25
6. Bacteriology and hygiene (bacteriologic methods, especially those relating to diagnosis; the application of hygienic methods of prophylaxis and treatment)	10
7. Obstetrics and gynecology (the general practice of obstetrics; diseases of women, their pathology, diagnosis, symptoms, and treatment, medical and surgical)	15
Total	100

Seven hours will be allowed for this examination.

Age limit, 25 to 55 years on the date of the examination.

Men only will be admitted to this examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D.C., or to the secre-

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tary of the Board of Examiners at any place mentioned in the list printed hereon, for application Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued Dec. 16, 1907.

Will You Help?

Having the insurance fight won, excepting only as against the New York Life, which is practically out of business in the State, our best energies, as individuals and as an organization are to be devoted this year, by direction of the House of Delegates, to securing pure drugs and to ridding ourselves of nostrums. The resolutions published herewith are direct and to the point. No doubt is left as to their meaning. It is particularly urged that you refuse to receive from the post office, copies of trade journals. Many of the great pharmaceutical houses get out such sheets and send them free to physicians, hoping to lure them into the use of their specialties. Most of these specialties, and all such so-called journals are conceived in fraud and brought forth in iniquity. Refuse to accept them and thus help to kill them.

Next, look through the pages of every medical journal to which you subscribe, whether it belongs to a State or other organization, or is supported by the members of the National Proprietary Association, the patent medicine vendors' collusive family, or what not, and if you find the nauseating advertisements of the blatant frauds already exposed by the Council on Pharmacy and Chemistry, write a personal letter to the editor,

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the publisher and each collaborator, calling their attention to such frauds. Do not talk about it! Write, and write today, and help to save our honorable profession from the vampires who exploit it, to its own shame and dishonor.

In addition to this we have arranged with the American Medical Association to keep a supply of the Manual of the Pharmacopeia and the National Formulary, on hand in our Journal office. Send 50 cents in money or stamps, and by return mail we will send you not only this valuable book, but also the latest revision of the List of New and Non-Official Remedies approved by the Council on Pharmacy and Chemistry of the American Medical Association, and the Propaganda against the use of Nostrums. In one of these two books will be found every medicinal agent necessary to any intelligent doctor. As suggested by one member at this meeting, let each of us get these little books and learn the honest remedies, that it may not be necessary to rely on the nostrums and our own ignorance.

Read these resolutions carefully, and by the same concert of action as won the insurance fight, do your best share toward winning this one. "United we stand, divided we fall!"

COMMITTEE ON PHARMACOLOGY.

WHEREAS, The American Medical Association has established a Council on Pharmacy and Chemistry, composed of scientists of world-wide reputation and standing, whose function is to examine pharmaceutical products in order to be able to inform the profession as to the actual composition of said products, and,

WHEREAS, After careful examination of many hundreds of said products, it has officially announced its approval of a large number of them, and, in order to make clear to the profession the methods and purposes of their work, have published exposures of a large number of the fraudulent preparations that have been foisted on the members of the profession and, through them, on the public, by interested owners and manufacturers, frequently laymen, ignorant of the use of drugs, except meretricious use, as examples of the much larger number

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which they have found of little or no value, or positively harmful, and,

WHEREAS, We believe that every physician in Kentucky is vitally interested in the work of this Council, and desires in every possible way to promote its usefulness and interests, and,

WHEREAS, The greatest aid to the nostrum manufacturers in their nefarious and avaricious work has been the medical press, whether controlled by medical organizations, individual members of the profession or interested lay-firms, and,

WHEREAS, We believe the time has arrived when the great profession of medicine, and all agencies controlled by it, should divorce itself permanently, finally and forever from those interests which, like ghouls, prey upon the sick and afflicted through the commercial sale of nostrums and dishonest so-called proprietary, medicines, now, therefore, be it

Resolved, By the Kentucky State Medical Association, in annual session assembled, that we heartily endorse the formation of the Council an Pharmacy and Chemistry, that we extend it our confidence and congratulations on the splendid work already accomplished, and that we pledge it our unanimous support in its purpose of freeing our profession and its publications from nostrum control, and, be it further,

Resolved, That, in pursuance of this object, we request each county society in Kentucky to devote a special session to consideration of this important question, with a view to securing the active aid of every licensed practitioner in the State, and that the Council of this Association be requested to omit from the advertising columns of our Journal all pharmaceutical preparations which are not manufactured in conformity with the U. S. Pharmacopeia or the National Formulary until they have been approved by the Council on Pharmacy and Chemistry of the American Medical Association; and, be it further

Resolved, That we request every physician in Kentucky to secure a copy of the abridged U. S. Pharmacopeia and Formulary, and be guided by this and the approval of the Council on Pharmacy in their use of medicines; ** and, be it further

Resolved, That our Council be directed to communicate with

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the editors, owners, collaborators and publishers of the medical journals of this country on this subject, and to announce to the profession of Kentucky, through the columns of our Journal such publications as are willing to assist the profession by freeing their columns of nostrum advertising, and we hereby pledge our support to such journals even if they find it necessary to increase their subscription rate, and further, be it

Resolved, That we expressly condemn the publication of so-called medical journals by interested manufacturers of nostrums, and request the profession of the State to decline to receive them.

*Reprinted from the *Kentucky Medical Journal,* November, 1907.

**Copies can be had from the *Kentucky Medical Journal,* Bowling Green, for 50 cents each.

DEAR SIR—At the recent Annual Meeting of the American Pharmaceutical Association the undersigned was directed to send to you a copy of the following resolutions:

WHEREAS, The American Medical Association, the American Retail Druggists, together with many State and local organizations and journals in both professions, have been for some years endeavoring to bring about a return to the practice of medicine based on the Pharmacopœia, and

WHEREAS, The Medical colleges are represented on the Committee of Revision of the U. S. Pharmacopœia, and

WHEREAS, It is manifest to the thoughtful men both in medicine and pharmacy that a very large number of medical men might be better informed regarding the Pharmacopœia as a book of reference and standards. Be it therefore

Resolved, That it is the sense of the American Pharmaceutical Association in convention assembled, that a great advance in the ethical practice of medicine and pharmacy will be made when the medical college make the Pharmacopœia a prescribed text-book, or book of reference, and require a familiarity with it in their examinations.

Resolved, That we request the governing authorities of all medical colleges in the United States to put into force such a

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ruling in their respective institutions as will insure in future classes a well grounded knowledge of materia medica and Pharmacology, as set forth in the Pharmacopœia.

Resolved, That the General Secretary be directed to transmit a copy of these resolutions to each medical college in the United States, and to the medical and pharmaceutical press.

Yours very turly,

CHAS. CASPARI, JR.,
General Secretary.

MIDDLE TENNESSEE MEDICAL SOCIETY.

At the annual meeting of the Middle Tennessee Medical Association, held in Nashville, the following officers were elected: Dr. E. H. Jones, Murfreesboro, President; Dr. William Litterer, Nashville, Vice-President; and Dr. R. L. Jones, Nashville, Secretary-Treasurer.

We extend our warmest sympathies to our distinguished confrere, Dr. D. J. Roberts, editor of the *Southern Practitioner,* upon the death of his son, Dr. Frederick Roberts, a recent graduate in medicine, who gave promise of achieving distinction in his chosen profession, and of being a source of pride and gratification to his bereaved father.

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Reviews and Book Notices

Immune Sera.—A Concise Exposition of Our Present Knowledge Concerning the Constitution and Mode of Action of Antitoxins, Agglutinins, Hæmolysins, Bacteriolysins, Precipitins, Cytotoxins and Opsonins. By Dr. Charles Frederick Boldnan, Bacteriologist, Research Laboratory, Department of Health, City of New York Second Edition, Rewritten. First Thousand. New York: John Wiley & Sons; London: Chapman & Hall, Limited. 1907.

This is a very opportune little work and should appeal to the progressive physician of the day who wishes to keep up with recent advances in this department of the newer medical science. It is a concise and clear exposition of the present state of knowledge of the subjects treated and is carefully and systematically arranged to meet the wants of those in search of information.

Compend of Surgery, for Students and Physicians.—Including Minor Surgery and a Complete Section on Bandaging. By Orville Horwitz, B. S., M.D., Professor of Genito-Urinary Surgery, Jefferson Medical College; Surgeon to St. Agnes Hospital; Fellow of the College of Physicians, Philadelphia, etc., etc. Sixth Edition, Revised and Enlarged. 195 Illustrations and 104 Formula. P. Blakiston's Son & Co., 1012 Walnut St. 1907.

This is the sixth edition of one of the most popular numbers of the Quiz Compend series. The manual has been increased greatly in size since the first edition, and very greatly improved and modernized in every respect. The utility of the work as a reference book for students and for practitioners who are to undergo State Board or other examinations is unquestioned and we feel sure this especial manual will add greatly to the value of the series.

A Text-Book of Practical Gynecology.—For Practitioners and Students. By D. Tod Gilliam, M.D., Emeritus Professor of Gynecology in Starling-Ohio Medical College, and Sometime Professor of Gynecology Medical College; Gynecologist to St. Anthony and St. Francis Hospitals; Consulting Gynecologist to Park View Sanitarium, Columbus, Ohio; Fellow of the American Association of Obstetricians and Gynecologists; Member of the American Medical Association, of the Ninth International Medical Congress, etc. Second Revised Edition. Illustrated with 350 Engravings, a Colored Frontispiece, and 13 Full-page Halftone Plates. 642 Royal Octavo Pages. Extra Cloth, $4.50, net; Half-

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morocco, Gilt-top, $6.00, net. Sold only by Subscription. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia.

The second edition of this eminently practical treatise has been received. The author has been markedly successful in his efforts to produce a work that will serve as a daily handbook for practitioners and for students striving to obtain a clear knowledge of gynecological technique. The careful revision the work has undergone in this edition has added materially to its value without increasing the bulk of the volume. We are sure that all who see the book will be impressed with its usefulness as a work of reference.

Progressive Medicine.—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, etc. Assisted by H. R. M. Landis, M.D., Visiting Physician to the Tuberculosis Department of the Philadelphia Hospital, to the White Haven Sanatorium and to the Phipps Institute; Demonstrator of Clinical Medicine in the Jefferson Medical College. Volume IV, December, 1907. Diseases of the Digestive Tract and Allied Organs, the Liver and Pancreas—Diseases of the Kidneys—Surgery of the Extremities, Fractures, Dislocations, Tumors, Surgery of Joints, Shock Anesthesia, and Infections—Genito-Urinary Diseases—Practical Therapeutic Referendum. Lea Brothers & Company, Philadelphia and New York. 1907.

This number of Progressive Medicine is more interesting than usual. We know of no medical publication of the day that is better calculated to present the most recent advances in medicine and surgery than this, and every wide awake physician should subscribe to the work so as to keep himself fully abreast with the present day progress of medicine and surgery.

Diseases of the Nervous System. Edited by Archibald Church, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence, Northwesten University, Medical Department, Chicago, Ill. An Authorized Translation from "Die Deutsche Klinik," Under the General Editorial Supervision of Julius L. Salinger, M.D., with 195 Illustrations in the Text, and Five Colored Plates. D. Appleton and Company., New York and London. 1908.

A careful examination of this work impresses us with the idea

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that it is one of the most valuable contributions recently made to medical literature,especially to all interested in this rather abstruse branch of medicine. It is presented under the editorship of a well known teacher of nervous diseases, from a translation from "Die Deutsche Klinik," and is composed of a number of able articles prepared by men of known experience and world wide reputation. The treatise is eminently practical and promises to be of the greatest assistance to the medical searcher. The list of contributors embraces some of the best known names in German neurological circles and the subjects selected are such as are sure to interest every one who desires the latest information upon these subjects. Space is too limited for us to give entire the list of contributions, so we select at random a small number so as to give our readers some idea of the character of the work: "Modern Aids in the Diagnosis of Diseases of the Brain," by E. Redlich, Vienna; "Lumbar Puncture," by H. Quenche, Kiel; Syringomyelia," by Fr. Schultze, Brun; "Tetanus of Adults," by L. V. Frankl, Hockwald, Vienna; "Hysteria," by Th. Zichen, Berlin, etc. The text is clear, concise and yet comprehensive throughout, the illustrations numerous and excellent, and the arrangement admirable.

Thirty-Fourth Annual Report of the Secretary of the State Board of Health of the State of Michigan, for the Fiscal Year Ending June 30, 1906.—By Authority, Lansing Michigan. Wynkoop, Hallenbeck Crawford Co., State Printers. 1907.

This report contains a great deal of interest to the sanitarian, and to the general practitioner. The arrangement and the compilation of statistical information is admirable.

The Medical Record: Visiting List or Physicians Diary for 1908.—New Revised Edition. New York: William Wood & Company, Medcal Publishers.

We are in receipt of this excellent Physician's Visiting List, and find it enlarged and changed so as to meet most admirably the daily needs of the practitioner. For convenience and adaptability it can not be excelled and we feel sure it will maintain its popularity with the medical profession of the day, as it has for many years in the past.

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Publisher's Department

The Local Treatment of Catarrhal Conditions Affecting the Upper Air Passages.

BY E. C. ROEMELE, M.D., FRANKFORT, KY.

Case 1. E. J., æt. 24. Diagnosis: chronic nasal catarrh. Duration, three years. Patient complained of a feeling of fullness in the nares and increase of the secretions, the character being thick and greenish, which dropped posteriorly into the pharynx, causing paroxysms of "hawking," which were more marked in the morning just after arising. The voice had a peculiar nasal intonation, the sense of smell was abolished almost entirely and hearing was impaired, due to the extension of the inflammation into the eustachian tubes. The patient also complained of a constant dull headache. I at once prescribed Glyco-Thymoline and had him use the K. & O. Nasal Douche every four hours, using the Glyco-Thymoline in 25 per cent solution. I directed him to spray his throat with an atomizer, using undiluted Glyco-Thymoline every four hours, and also gave him one teaspoonful of Glyco-Thymoline four times a day internally. This was done on account of the catarrhal condition of his stomach. After two weeks the hawking had ceased, his voice took on a more natural tone, and hearing and smelling senses were improved. He continued to improve when after fifteen weeks he was entirely cured. There has been no return during the past ten months.

Case II.—Willie Green, æt. 7. Diagnosis: Hypertrophy of tonsils. This case was referred to me by Dr. D., to have his tonsils removed. The doctor stated that he had used every known remedy to reduce them, his last remedy being iodine, which he applied in undiluted form, also giving him internal treatment. When I examined his throat Ifound the tonsils extremely large, so large in fact that the opening was not as large as a slate pencil. He was a terrible mouth-breather and could easily be heard from one room to another. He would not consent to the ope-

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ration and his mother would not permit us to administer chloroform. I then decided to attempt to cure them without the operation. I prescribed a pound bottle of Glyco-Thymoline, and directed the mother to spray his throat thoroughly every three hours with an atomizer. She called in again in one week and the swelling had subsided, and the child ceased to breathe as hard as he had breathed. This same treatment was continued. He was returned to my office in three weeks when the tonsils were normal in size; he kept his mouth closed when he slept. The treatment was continued several weeks longer, when he was discharged as cured. It has now been eight months and no return whatever of any symptoms of the disease.

Case III.—Ella N., æt. 27. Diagnosis: Rhino-pharyngitis. Duration, six years, presenting characteristic symptoms of severe type. Patient had to vomit after each meal on account of hawking the mucus out, which she said would drop into her throat. When she would arise in the morning she would have to hawk and cough half an hour before she would be relieved of the mucus which she said came out of her throat in the shape of round balls. I directed her to use the K. & O. Douche, filling it with Glyco-Thymoline pure, flushing out the nasal cavities three times a day, and directed her to spray her throat with Glyco-Thymoline, one part to one of water, three times a day. Improvement was immediate. After five weeks, instead of using the Glyco-Thymoline in the douche in undiluted form, she was directed to dilute it with one part of water. After the fourth day she ceased vomiting and hawking. This treatment was continued, however, for four months, when she was discharged cured.

KRESS & OWEN COMPANY,
210 Fulton Street, New York, U. S. A.
Manufacturers Glyco-Thymoline and K. & O. Nasal Douche.

Merle (Burleson Co.), Tex., Nov. 24, 1906.

The Anasarcin Chemical Co., Winchester, Tenn.

Yours of the 25th of October was received. In answer to same I will say that your tablets excel anything it has been my pleasure to use; they are exactly as you represent them, and no

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mistake is made by any physician using them. My confidence in them is centered in the following case: A German, 42 years, suffering from gout, feet swollen, appetite gone, cirrhosis of the liver, constipation, heart's action very bad. The man was a hard drinker both of whiskey and beer; he could not sleep at night without morphine. I cleared the liver and bowel with a calomel and pod. purge, then commenced your tablets. He began to improve from the start using the tablets as directed, using all and only one more box. He is now a new man; sleeps all right; no swelling of the feet; heart's action normal; eats sour kraut same as ever, and no taste for any beverages whatsoever. He calls the tablets "some buckshot."

I intend to use these tablets in all my cases where they are indicated.

Wit h highest regards, I am Respectfully yours,
J. P. CARRINGTON, M.D.

Notwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable Syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including iron, quinine, and strychnine, etc., in perfect solution, and is not liable to the formation of fungous growths.

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